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Dear Patient: Please complete this health history questionnaire to the best of your ability and give it to your surgeon's office team. If you are not sure of any answer, check "not sure". You can add details in the "Comments" box.

Name:

Health Card No.: **VC:**

Profession:

Address:	☎ Home	Cell
Email Address:	Preferred language: ❑ English ❑ French ❑ Other (specify):	
Height: feet/inches or cm	**Weight:** lbs or kgs	For office use only **BMI**
Family Physician ☎	Date of birth (yyyy/mm/dd)	❑ Male ❑ Female

HEART

Do you have:	Yes	No	Not sure	Comments	
1. Any heart problem? (e.g., heart attack, murmur, angina, blockages, angioplasty, stent, valve problems, irregular heartbeat, heart surgery, heart failure).				*Specify:*	*
2. High blood pressure?				❑ not well controlled ❑ well controlled	*
3. Chest pain or breathlessness after climbing 2 flights of stairs?					*
4. A pacemaker or an implantable defibrillator?					*
5. Do you take Aspirin (ASA) regularly?				*Why?*	
6. A prescription for blood thinners? (e.g., warfarin, coumadin, plavix, dabigatran, rivaroxaban)					*
7. An artificial heart valve?					*
8. Any other artificial implants that require you to take antibiotics before surgery, or going to the dentist? e.g., knee, hip, other).				*Specify:*	
9. Any other heart issues?				*Specify:*	

BREATHING

Do you have:	Yes	No	Not sure	Comments	
10. Emphysema, chronic obstructive pulmonary disease (COPD) or chronic bronchitis?					*
11. Asthma?				❑ not well controlled ❑ well controlled	*
12. Sleep apnea? (diagnosed by a physician)					*
13. A problem lying flat for at least 30 minutes because of difficulty breathing?					*

BREATHING

Do you use:	Yes	No	Not sure	Comments	
14. A breathing machine to help you sleep?					*
15. Inhalers (puffers)?				*How often?*	
16. Oxygen at home to help you breathe?					*
17 Do you smoke tobacco of any kind? (e.g., cigarettes, cigars, pipes).				*Specify:*	
				number /day:	
				number of years:	
18. Have you had shortness of breath for which you have been admitted to hospital within the last 2 months?					*
19. Have you had pneumonia in the past 2 months?					*
20. Do you have any other breathing issues?					

BLOOD PROBLEMS

Have you ever been treated for:	Yes	No	Not sure	Comments	
21. Sickle cell anemia?					*
22. Anemia (low blood count)?					
23. A bleeding disease or problem?				*Specify:*	*
24. Blood clots (in your lungs, legs or other)?				*Specify:*	*
25. Have you had a blood transfusion within the last 3 months?					
26. Do you have any personal or religious reasons for refusing to have any blood products given to you?					*

NEUROLOGICAL

Do you have/have you had:	Yes	No	Not sure	Comments	
27. Memory problems or confusion?					*
28. A history of extreme confusion after an operation?					*
29. A disease that affects your muscles and nerves?					*
30. A stroke or stroke- like symptoms in the past?					*
31. Any aneurysm?					*
32. Epilepsy or convulsions?					*
33. Dizziness?					
34. Fainting spells?					*

OTHER IMPORTANT MEDICAL INFORMATION

	Yes	No	Not sure	Comments	
35. Do you have family (blood relatives) who have had serious problems following an anesthetic?					*
36. Have you had serious problems following an anesthetic (e.g., malignant hyperthermia)?				*Specify:*	*
37. Do you have trouble opening your mouth, jaw or moving your neck?					*

OTHER IMPORTANT MEDICAL INFORMATION

	Yes	No	Not sure	Comments	
38. Do you have a chronic pain disorder?					*
39. Are you pregnant?					*
40. Is there a possibility that you could be pregnant?					
41. Are you diabetic?				❑ on insulin	*
				❑ on diabetic pills	
				❑ diet controlled	
42. Are you on dialysis?					*
43. Do you have kidney disease?					*
44. Do you have thyroid disease?				❑ not well controlled	*
				❑ well controlled	
45. Do you have a urinary tract infection?					
46. Have you had an infection requiring isolation in the hospital?					
47. Do you currently have a cold, chest infection or fever?					*
48. Are you HIV positive?				❑ not on treatment	*
				❑ on treatment	
49. Do you have liver disease?					*
50. Have you had an organ transplant?					*
51. Do you have stomach ulcers, heartburn or a hiatus hernia?					
52. Do you have arthritis?				❑ rheumatoid arthritis	*
				❑ osteoarthitis	
53. Do you have an autoimmune disease? (e.g., lupus)					*
54. Have you had radiation treatment?				❑ to the head or neck	*
				❑ abdomen	
				❑ other:	
55. Do you drink more than 14 alcoholic beverages per week?				*Total per week:*	*
56. Do you use any street drugs?					*
57. Do you have a hearing impairment or wear a hearing aid?					

ALLERGIES

Do you have allergies to:	Yes	No	Not sure	Comments	
58. Latex?					
59. Eggs?					
60. Other food?					
61. Medication?				*Name?*	
62. Metal?					
63. Anything else?					

DISCHARGE PLANNING AND MOBILITY

	Yes	No	Not sure	Comments	
64. Do you use a wheelchair, walker, cane, scooter or other aid?					
65. Do you have problems with your balance?					
66. Have you had a fall in the last 3 months?					*
67. When discharged, do you have a responsible adult to drive you home following your surgery?					
68. Do you have someone available to stay with you overnight and help care for you?					
69. Do you presently receive services from home care? (CCAC)					
70. Do you live in a retirement home, boarding home or long term care facility, or other?				*Specify:*	
71. Do you live more than 100 km away from The Winchester District Memorial Hospital?					
72. Do you **have to** climb stairs when you are at home?				*How many?*	

LIST ANY SURGERIES OR MINOR PROCEDURES USING ANESTHETIC YOU HAVE HAD IN THE PAST.

Procedure	Year	Procedure	Year
1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	

LIST ANY OTHER UPCOMING PROCEDURES (other than your surgery) AND WHEN THEY ARE SCHEDULED?

Procedure	Month/Year	Procedure	Month/Year
1.		5.	
2.		6.	
3.		7.	
4.		8.	

INDICATE PHARMACY NAME AND TELEPHONE NUMBER	
Your pharmacy name:	Phone number (or location of pharmacy) ( )

LIST ALL OF THE MEDICATIONS THAT YOU TAKE (INCLUDING HERBAL MEDICATION, VITAMINS, AND NON PRESCRIPTION DRUGS). ATTACH LIST IF NECESSARY.	
1.	13.
2.	14.
3.	15.
4.	16.
5.	17.
6.	18.
7.	19.
8.	20.
9.	21.
10.	22.
11.	23.
12.	24.

Do you have any other illness, limitations or any other concerns we should know about? ❑ Yes ❑ No
Specify:

Patient Health History Questionnaire completed by:

❑ Patient ❑ Family Member ❑ Health Care Provider ❑ Other (specify):

Print name(s)	Signature	Date (yyyy/mm/dd)	Time

IMPORTANT: Please remember to let your surgeon know if you think you are getting a cold, flu or illness or if you start taking any new medications.

Thank you!