SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE
iCare

DEMOGRAPHIC LABEL

Adult Questionnaire
Pre-Surgical Patient Information Form

PLEASE USE A PEN, PREFERABLY BLACK INK, TO FILL OUT THIS FORM.

To be completed by patient or designate. Date: _____(dd/mm/yyyy)

Print name: _____

English speaking ☐ Yes ☐ No
If no, language spoken: _____
Accompanied by:_____

Able to read English: ☐ Yes ☐ No
Interpreter required: ☐ Yes ☐ No
Relationship:_____

Glasses/contact lenses: ☐Yes ☐ No

Hearing aid: ☐ Yes ☐ No ☐ Right ☐Left ☐Both

Do you require assistance walking? ☐Yes ☐No ☐ Cane ☐ Walker ☐ Wheelchair

Have you had any falls recently? ☐Yes ☐No

Your day surgery will be cancelled if you do not have a responsible adult to provide transportation home and someone to remain with you overnight. <u>You are required to arrange for help at home when leaving the hospital.</u>
Have you arranged for a responsible adult to pick you up and stay with you overnight? ☐ Yes ☐ No
Have you arranged for help at home? ☐ Yes ☐ No

PREADMIT : P: _____ BP: _____ O_2 Sats _____ BG (am of visit): _____ RCRI score: _____

DAY SURGERY: P: _____ BP: _____ O_2 Sats _____ BG: _____

Instructions: Please circle 'Yes' or 'No' for each question. Fill in blanks for details. The nurse will review the questionnaire with you during your appointment.

	HEART and ARTERIES **Do you have or have you ever had:**	**NURSING ASSESSMENT**
YES NO	Are you limited WALKING on ground level? Distance non stop: Less ←1 block—1 mile → MORE	
YES NO	HEART ATTACK? When? Treatment? Did you see a cardiologist?	
YES NO	ANGINA or CHEST PAIN? How often? Degree of exertion:	
YES NO	HIGH BLOOD PRESSURE? Since when?	
YES NO	ABNORMAL HEART VALVES or MURMUR?	
YES NO	CONGESTIVE HEART FAILURE? Most recent hospitalization?	
YES NO	IRREGULAR HEART BEAT?	
YES NO	a PACEMAKER or implanted DEFIBRILLATOR? Since when?	
YES NO	a STROKE or TIA? When?	

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	LUNGS/RESPIRATORY Do you have or ever had:	
YES NO	Do you SMOKE? Packs per day? For how many years?	
YES NO	Did you used to smoke and stopped? Year you stopped:	
YES NO	ASTHMA (wheezing)?	
YES NO	COPD/ EMPHYSEMA/ CHRONIC BRONCHITIS?	
YES NO	SLEEP APNEA? If so, do you use CPAP? **YES NO** _____**cm H_2O**	
YES NO	recent COUGH/ COLD/ RESPIRATORY INFECTION?	
	GENERAL **Do you have or have you ever had:**	**NURSING ASSESSMENT**
YES NO	DIABETES? Since when? _____ Diet only? Tablets? Insulin? BG average _____	
YES NO	HEARTBURN/ GASTROESOPHAGEAL REFLUX?	
YES NO	Have you lost weight in the past 6 months WITHOUT TRYING to lose this weight?	
YES NO	Have you been eating less than usual FOR MORE THAN A WEEK	
YES NO	THRYOID PROBLEMS? Since when?	
YES NO	Do you use 'RECREATIONAL' drugs? MARIJUANA? Others? How often? _____	
YES NO	Do you drink ALCOHOL/ WINE/ BEER? How much? _____	
YES NO	KIDNEY DISEASE?	
YES NO	RHEUMATOID ARTHRITIS?	
YES NO	Any WOUNDS/ULCERS that are being treated? Any open cuts, scrapes or skin infection? Homecare? **YES NO**	
YES NO	LIVER DISEASE/HEPATITIS?	
YES NO	CANCER? Type: _____ Year_____ Radiation? Chemotherapy?	
YES NO	MENTAL HEALTH PROBLEMS?	
YES NO	SEIZURES? Most recent seizure: _____	

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	GENERAL Do you have or have you ever had:	NURSING ASSESSMENT
YES NO	BLOOD CLOTS in legs or lungs? Year: _____	
YES NO	History of MRSA?	
YES NO	History of VRE?	
	Do you have a history of the following BLEEDING DISORDERS ☐ Hemophilia ☐ Von Willebrands Disease ☐ Anemia ☐ Iron Infusions ☐ Blood Transfusions When? ☐ Other_____	

	ANESTHETIC HISTORY Do you have or ever had:	
YES NO	any unusual reaction to anesthesia? Family member? YES NO	
YES NO	history of MALIGNANT HYPERTHERMIA? Family member? YES NO	
YES NO	Have you taken oral STEROIDS (Prednisone) in the past 6 months?	
YES NO	NEUROMUSCULAR DISEASE	
YES NO	LATEX allergy?	
YES NO	Teeth LOOSE or CAPPED?	
YES NO	DENTURES? Partial? Full?	

HOSPITALIZATION IN LAST 5 YEARS

Medical Conditions Other Than Surgery		Major Surgical History	
Reason	**Date**	**Reason**	**Date**

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Is there anything else you would like to add?

Patient signature: _____
OR
Designate signature: _____ **Relationship:** _____

Reviewed by:
Nurse signature:_____ **Date:** _____
(dd/mm/yyyy)

NURSING NOTES