



PRE-OPERATIVE PATIENT HEALTH QUESTIONNAIRE

DATE: _____

Patient Name _____ D.O.B _____ PHN _____

This patient Questionnaire is being completed by: Patient Support Person/Family Member Healthcare provider

If NOT completed by patient, please give explanation why _____

Dear Patient,

This is a very important document for you to complete before you have surgery. The VGH Pre-Admission Clinic will use the information you provide to determine your surgical care needs.

This comprehensive questionnaire asks lots of questions about your medical history to ensure that the clinic can safely assess your surgical risks, as well as help prepare you for surgery.

Please complete this form as best you can before returning it to your Surgeon's office. If you are not sure what a question means, please add as much detail as you can and you will be asked for more information at your pre-admission appointment. There is extra writing space at the end of the Questionnaire, if needed.

Please place an 'X' in either the No or Yes column for each question below where indicated.

Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
1. ANESTHESIA				
Any surgical procedure under general anesthesia, spinal, epidural, nerve block, or local anesthesia?			List procedure name, where and when. Expand on last page if needed. _____ _____ _____	
Personal history of problem with anesthesia?			What / Where / When _____ _____	
Blood related family member with a history of serious problem with anesthesia?			What _____ _____	
Admitted to hospital or visits to the emergency department in the past year?			List reason, which hospital and when: Please expand on last page if needed. _____ _____ _____	
2. FUNCTIONAL STATUS				
How much difficulty do you have in lifting and carrying 10 pounds?	None = 0 <input type="checkbox"/> Some = 1 <input type="checkbox"/> A Lot or Unable = 2 <input type="checkbox"/>			
How much difficulty do you have walking across a room?	None = 0 <input type="checkbox"/> Some = 1 <input type="checkbox"/> A Lot, use aids, or unable = 2 <input type="checkbox"/>			
How much difficulty do you have transferring from a chair or bed?	None = 0 <input type="checkbox"/> Some = 1 <input type="checkbox"/> A Lot, or unable without help = 2 <input type="checkbox"/>			
How much difficulty do you have climbing a flight of 10 stairs?	None = 0 <input type="checkbox"/> Some = 1 <input type="checkbox"/> A Lot or Unable = 2 <input type="checkbox"/>			

RN Initial _____



PRE-OPERATIVE PATIENT HEALTH QUESTIONNAIRE

PCIS LABEL

Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
How many times have you fallen in the past year?			None = 0 <input type="checkbox"/> Some = 1 <input type="checkbox"/> A lot = 2 <input type="checkbox"/> If you have fallen in the past, what caused the fall(s) _____ _____	Total Score _____
How often do you engage in activities that are light to moderately strenuous? (eg. going for a walk, jogging, gardening, dancing)?			Once a week or less <input type="checkbox"/> More than once a week <input type="checkbox"/> Within that week, on average how many times? _____ On average how many minutes each time? _____	
Do you use a mobility aid such as wheelchair, walker, cane, or scooter?			If yes, what is the reason? _____ _____	
Do you require assistance with activities of daily living? (eg. personal hygiene, dressing, feeding, ambulating)?			If yes, what form of assistance do you have? _____ _____	
Problems with hearing?			Hearing aids? <input type="checkbox"/> Specify _____	
Problems with eyesight?			Specify _____ _____	
3. BREATHING / RESPIRATORY				
Obstructive sleep apnea (stop breathing while asleep) diagnosed by Sleep Study?			If yes: Date and where? _____ Was the Sleep Study done in Sleep Lab <input type="checkbox"/> or Home Sleep Study <input type="checkbox"/> Do you use a CPAP machine? Yes <input type="checkbox"/> No <input type="checkbox"/> Tried CPAP but not using regularly <input type="checkbox"/>	
Asthma, emphysema, chronic bronchitis, or chronic obstructive pulmonary disease (COPD)?			If yes: Have you previously sought urgent or emergent care for your breathing? Yes <input type="checkbox"/> No <input type="checkbox"/> Oral steroid in the past year? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Home oxygen use?			If yes: Do you use all the time? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you use only at night? Yes <input type="checkbox"/> No <input type="checkbox"/> L/min _____	
Shortness of breath with normal activity or lying flat?				
Have you been seen by a Lung Specialist (Respirologist) in the past 5 years?			Name of Specialist Doctor _____ Where and when _____ _____	
Lung (pulmonary) function test (PFT) in the past 5 years?			Where and when _____ _____	

RN Initial _____



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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
Any other breathing or lung condition?			Describe _____ _____	
4. HEART / CARDIOVASCULAR				
High blood pressure?				
Do you take medication to treat your blood pressure?				
Any heart related symptoms at rest or with physical activity?:				
• Chest pain, pressure, discomfort			What brings it on/triggers _____ _____	
• Shortness of breath or breathlessness			What brings it on/triggers _____ _____	
• Palpitations or irregular heartbeats			What brings it on/triggers _____ _____	
• Fainting or blackout			What brings it on/triggers _____ _____	
Any known heart related problem?:				
• Heart murmur				
• Angina, heart attack, heart surgery, angioplasty, stent			If yes, when and where were you treated or had your operation _____ _____	
• Heart valve problem (including repair, replacement or leaking)			Please describe your valve issue _____ _____ Please provide details, of any previous operations _____ _____	
• Weak Heart (e.g Heart failure, CHF)			How many years? _____ Who manages your heart failure? _____ _____	
• Pacemaker or defibrillator (ICD)?			Please specify type of device _____ When was it implanted and why? _____ _____ Location of implant _____ When was its function last tested? _____ _____ Which clinic manages your pacemaker? _____ _____ Please provide a copy of your pacemaker card.	
Any known vascular problem?:				
• Peripheral vascular disease (blood flow problem in arms or legs)			Please describe the nature of your condition _____ _____ _____	
Any one of the following tests in the past 5 years?:				
• Followed by a Cardiologist			Name _____	
• Exercise stress test (treadmill)			When, where _____ _____	

RN Initial _____



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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
• Nuclear medicine heart scan (e.g Myocardial Perfusion Imaging Test- MIBI)			When, where _____ _____	
• Heart or coronary catheterization (angiogram)			When, where _____ _____	
• Heart echo test (ultrasound)			When, where _____ _____	
• Holter monitor			When, where _____ _____	
Any other heart related conditions?			Describe _____ _____	
5. NEUROLOGICAL				
Do you have any memory problems?			Please explain _____ _____	
Have you been diagnosed with dementia?			Known MMSE or MOCA Score? _____	
Do you get confused or disorientated?			What were the circumstances? _____ _____	
Disease affecting muscles and nerves?			Details: _____ _____	
Stroke, "mini-stroke" or transient ischemic attack (TIA) in the past?			When? _____ Permanent deficits? _____ Please detail any ongoing effects? _____ _____	
Traumatic brain injury that continues to affect your function?			When? _____ Effect on function: _____ _____	
Spinal cord injury?			Injury level _____ Any autonomic dysreflexia Yes <input type="checkbox"/> No <input type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia <input type="checkbox"/> Spine surgery date _____ Tracheostomy? Yes <input type="checkbox"/> No <input type="checkbox"/> Ventilatory Supports such as CPAP, BIPAP, Home Ventilator? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have you had epilepsy, convulsions, or seizures in the past?			Date of last seizure _____	
Have you been seen by a Neurologist in the past 5 years?			Name _____ Where and when _____ Type of condition if not mentioned above: _____ _____	

RN Initial _____



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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
Do you have mental health concerns such as anxiety, mood disorders, post-traumatic stress disorder, psychosis, or phobias?			If yes, are you worried about worsening symptoms during or after hospitalization? Yes <input type="checkbox"/> No <input type="checkbox"/>	
6. BLOOD PROBLEMS / HEMATOLOGICAL				
Daily aspirin / ASA usage?			Reason _____ _____	
Prescription of blood thinner? <input type="checkbox"/> Plavix (clopidogrel) <input type="checkbox"/> Brilinta (ticagrelor) <input type="checkbox"/> Coumadin (warfarin) <input type="checkbox"/> Xarelto (rivaroxaban) <input type="checkbox"/> Pradaxa (dabigatran) <input type="checkbox"/> Eliquis (apixaban) <input type="checkbox"/> Heparin, low molecular weight heparin (eg. dalteparin, enoxaparin) <input type="checkbox"/> Other _____			Reason for medication: _____ _____ Do you have instructions on managing this medication at the time of surgery? Yes <input type="checkbox"/> No <input type="checkbox"/> What instructions have you been given by your healthcare provider? _____ _____ _____	
Have you been told by a medical doctor that you have a bleeding disorder (not including blood thinner medications)?			If yes, what kind do you have? Hemophilia <input type="checkbox"/> Von Willebrand disease (vWD) <input type="checkbox"/> Other: _____	
Have you been seen by a Hematologist (blood doctor) in the past 5 years?			Reason _____ Name _____ Where and when _____	
An advanced directive refusing blood transfusion?			Reason for refusal _____ _____	
Have you been told by a health care professional that you have special blood requirements such as:				
a) Blood antibodies or given a special antibody card to carry?				
b) Irradiated blood?			Reason and Ordering Physician (who told you that you needed irradiated blood) _____	
c) IgA deficiency?				
Have you been transfused with red cells or platelets in the last 90 days?				
Are you pregnant or have been within the last 90 days?				

RN Initial _____



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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
7. NUTRITION				
Have you lost weight in the past 6 months WITHOUT TRYING to lose weight?				
Have you been eating less than usual FOR MORE THAN ONE WEEK?				
8. SUBSTANCE USE				
Have you used nicotine product within the last six months? (e.g. smoking, vaping)?			Type _____ If not currently, when did you quit? _____ Would you like help to stop smoking? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no to previous question, were you a regular cigarette smoker in the past?			If yes: How many years did you smoke for? _____ In what year did you stop smoking? _____	
Have you used cannabis product within the last six months? (including oils, edibles)			Type _____ Amount per week _____	
Do you consume alcohol?			Type _____ Number of drinks per week _____ How many times in the last year have you had 4 or more drinks (if female) or 5 or more drinks (if male), on one occasion? _____	
Do you use other recreational drugs?			Type _____ Route: Oral <input type="checkbox"/> Injection <input type="checkbox"/> Inhale <input type="checkbox"/> Amount per week _____ Are you on an opioid agonist therapy? Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. CHRONIC PAIN				
Do you have chronic pain?			If yes, where do you experience pain? _____	
Have you ever had a bad experience with postoperative pain management or use of opioid for pain management?			If yes, please explain: _____ _____ _____	
Have you ever been seen by a hospital-based complex pain service, outpatient chronic pain clinic, or transitional pain clinic?			If yes, When _____ Where _____	
In thinking about your pain, how much do you agree with the statements on the right? Please answer in a scale of 0 to 4. 0 = not at all 1 = to a slight degree 2 = to a moderate degree 3 = to a great degree 4 = all the time			Statements: • It's awful and I feel that it overwhelms me. _____ • I can't keep it out of my mind. _____ • I keep thinking how much it hurts. _____ • I keep thinking how badly I want the pain to stop. _____	
				Total Score _____ RN Initial _____



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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
How intense has your pain been on average over the past week ?			Please rate your pain by circling the one number that best describes your pain on AVERAGE: NO 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE	Rating_____
Do you use opioids or narcotics for managing your pain?			Name, dose, frequency_____	
			Prescriber_____	
			Do you want help reducing your opioid pain medications prior to surgery? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you use non-opioids or non-narcotic medications for managing your pain?			Please list any medications in the medication box on page 9	
10. OTHER MEDICAL PROBLEMS				
Diabetes?			How it is controlled: Diet <input type="checkbox"/> Pills <input type="checkbox"/> Insulin <input type="checkbox"/> Last known HbA1C _____ Have you had any complications? (eg. eyes, neuropathy, kidney disease, foot ulcer) Yes <input type="checkbox"/> No <input type="checkbox"/>	
Kidney disease?			Dialysis – route, schedule_____	
			Other_____	
Do you have any problems passing urine?			Reason_____	
Do you have a urinary catheter?			Indwelling urethral <input type="checkbox"/> Suprapubic <input type="checkbox"/> Intermittent self-catheterization <input type="checkbox"/>	
Do you have any problems with your bowels?			Reason_____	
Liver disease (eg. hepatitis, cancer, cirrhosis)?			If yes, what is the diagnosis? _____	
Solid organ transplant?			Which organ? _____ When? _____	
Arthritis?			Osteoarthritis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Arthritis affecting neck / cervical spine <input type="checkbox"/> Other_____	

RN Initial _____



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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
<p>Infections? (Tick the box of any that apply):</p> <ul style="list-style-type: none"> • HIV <input type="checkbox"/> • Hepatitis B or C <input type="checkbox"/> • Recent or current cold, chest infection, or fever <input type="checkbox"/> • Herpes with lesions or Shingles with lesions <input type="checkbox"/> • Exposure to: Measles <input type="checkbox"/>, Mumps <input type="checkbox"/>, Varicella <input type="checkbox"/> in past 2 weeks • MRSA, VRE <input type="checkbox"/> • UTI <input type="checkbox"/> • TB (active) <input type="checkbox"/> • TB (exposure to in past 2 months) <input type="checkbox"/> • Other _____ 			<p>Treatment _____</p> <p>Did you have complications from disease or treatment? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Have you had a resistant bacteria that required isolation? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, which one _____</p> <p>If chest infection:</p> <ul style="list-style-type: none"> •When _____ •Current symptoms _____ •Did you have a COVID test and what was the result _____ 	
<p>In the last 12 months, have you been admitted to a hospital in Fraser Health Authority Acute Care overnight or admitted overnight to a hospital outside of Canada?</p>			<p>Specify where _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>Do you have any rashes, cuts or open wounds?</p>				
<p>Are you on hormonal birth control?</p>				
<p>Cancer within the last 5 years (other than relating to reason for surgery)?</p>			<p>Location / type _____</p> <p>Chemotherapy Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Date of last treatment _____</p> <p>Radiation therapy Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Date of last treatment _____</p> <p>Complications from treatment Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Where have you had treatment _____</p> <p>_____</p> <p>_____</p>	
<p>Vascular access device (IVAD, PICC, Portacath)?</p>			<p>Specify device _____</p> <p>What is it normally flushed with? _____</p>	
<p>Autoimmune disease? (e.g Lupus, M.S)</p>			<p>Diagnosis, if known _____</p> <p>Does it affect heart, lungs, kidneys, liver, blood clotting, skin? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>Any other medical problems not already mentioned?</p>			<p>Please expand if yes: _____</p> <p>_____</p> <p>_____</p>	

RN Initial _____



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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
11. MEDICATIONS				
Do you take any medications? (Including prescription, over the counter, supplements, vitamins and/or herbal)			Please list all the medications that you take: Name, dose and frequency (Attach a list if necessary or use space at end of Questionnaire) _____ _____ _____ _____	
12. ALLERGIES				
Do you have any allergies?			Latex <input type="checkbox"/> Metal <input type="checkbox"/> IV Contrast Dye <input type="checkbox"/> Antibiotics <input type="checkbox"/> _____ Medications <input type="checkbox"/> _____ Food <input type="checkbox"/> _____ Other <input type="checkbox"/> _____	
13. OTHER INFORMATION				
Do you have a support person/healthcare representative?			Name of support person/representative _____	
What is your living situation?			Home <input type="checkbox"/> Care Facility <input type="checkbox"/> Homeless <input type="checkbox"/> Live Alone <input type="checkbox"/> Assisted Living <input type="checkbox"/>	
Who is picking you up from hospital when you are ready to go home?			Name _____ Number _____	
Do you have a Living Will/Advance Directive?				
Are you using homecare assistance?			Private <input type="checkbox"/> Public <input type="checkbox"/> Health Authority _____	
Indigenous Community/Nation (if you wish to self identify)			Please specify _____ _____	
Do you speak conversational English?			If no, what language do you speak? _____	
Current Height				
Current Weight	_____ kg or lbs (please circle)			BMI _____
Daytime telephone number				
Cellphone				
Email				
Alternate Email				
Next of Kin telephone number				

Signature of person completing the form:

PAC RN	
Signature	
Date	

