



St. John Hospital

Pre-surgical Screening Medical Questionnaire

Page 1 of 2 PATIENT LABEL

Date: _____ Name: _____

Date of birth: _____ Height (estimate): _____ Weight: _____

Previous surgeries

List any previous surgeries you have had, noting the procedure and approximate year.

Have you or anyone in your family, ever had problems with anesthetic? No Yes

Describe: _____

Do you have allergies to food, medications or Latex? No Yes

Allergy	Reaction

List your medications

(Blood thinners, insulin, inhalers and any over the counter medications such as Aspirin, vitamins or herbal medications)

Do you smoke? No Yes Number per day: _____ Number of years smoked: _____

Ex-smoker: No Yes When quit: _____ Number per day: _____ Number of years smoked: _____

Have you used any tobacco products in the last 6 months? No Yes

If yes: Are you aware that stopping smoking before surgery lowers the risk of surgical complications and improves healing? No Yes N/A

Have you been referred to QuitNow and Health Link BC (8-1-1) for provincial smoking cessation services? No Yes N/A

Do you drink alcohol? No Yes → Number of drinks per week: _____

Do you use recreational drugs (i.e. marijuana or cocaine)? No Yes → Specify: _____



Do you have or have you ever had? (Circle or check appropriate box)

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Heart failure/fluid on lungs	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Hiatus hernia/heartburn
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker or defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease/jaundice/hepatitis A, B or C (circle)
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/bronchitis/emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problem
<input type="checkbox"/>	<input type="checkbox"/>	Blackouts/faints/dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Clotting disorders
<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease/weakness	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/neurological disease	<input type="checkbox"/>	<input type="checkbox"/>	Throat/neck tumor

Have you ever been diagnosed with sleep apnea? No Yes

If yes: Do you use a CPAP (breathing machine)? No Yes

If no: Snore loudly (loud enough to be heard through closed doors)

Been observed to stop breathing while sleeping?

Excessively tired during the day?

High blood pressure or been treated for it?

Neck size 40 cm (16 inches) or greater?

Do you have chronic pain problems? No Yes → Explain: _____

Cancer/chemotherapy/radiation: No Yes → Last treatment date: _____

Do you have anxiety or panic attacks? No Yes → Explain: _____

Other major health problems or concerns? No Yes → List/describe: _____

Could you be pregnant? No Yes

Have you ever received blood products or a blood transfusion? No Yes → Have you ever had a reaction? _____

Do you require assistance with household tasks or personal care? No Yes → Specify: _____

Do you mobilize/move around your home independently? Yes No → Explain: _____

Are you able to climb two sets of stairs? Yes No → Explain: _____

Do you have an Advance Care Plan (written record of beliefs/values/wishes for health care treatments)? No Yes

Do you have an Advance Directive (specific instructions that must be followed regarding your care)? No Yes

During weekdays, what is the best time to contact you? _____ Preferred time: _____

Do you need an interpreter to help you? No Yes → Explain: _____

Home: _____ Cell: _____ Office: _____

Email: _____

Information obtained from: _____ Relationship to patient: _____