northern health
the northern way of caring

St. John Hospital

Pre-surgical Screening Medical Questionnaire

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: _____

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Save to Email to docsvhf@uniserve.com

Print Form

PATIENT LABEL

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

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

☐ Been observed to stop breathing while sleeping? ☐ Neck size 40 cm (16 inches) or greater?

☐ Excessively tired during the day?

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: _____