HPHA
HURON PERTH HEALTHCARE ALLIANCE

HPHA PRE-OPERATIVE/PRE-PROCEDURAL PATIENT QUESTIONNAIRE

Name:
Date of Birth:
(YYYY/MM/DD)

Dear Patient: Please complete this health history questionnaire the best that you can. Please add details to your answers in the "comments" box. There are four (4) pages to be completed.

PLEASE BRING THIS FORM WITH YOU TO YOUR PROCEDURE/SURGERY/PRE-ANAESTHETIC APPOINTMENT

QUESTION	YES	NO	COMMENTS
Have you ever had an anaesthetic?			If yes, what type? ☐ General ☐IV Sedation ☐Local ☐Spinal/Epidural
Have **you** ever had any problems with anaesthesia? ☐severe nausea/vomiting after surgery ☐malignant hyperthermia ☐pseudo cholinesterase deficiency ☐been told that you have a 'difficult airway' or that placing a breathing tube in your airway is difficult? ☐other (please specify in comments)			
Has a **family member (related by blood)** ever had a serious problem after receiving an anaesthetic? ☐pseudo cholinesterase deficiency ☐malignant hyperthermia ☐other (please specify)			
Have you ever had: ☐heart murmur ☐heart failure (fluid in your lungs) ☐irregular heartbeat ☐heart valve problem ☐chest pain ☐chest tightness ☐heart attack			
Do you have: ☐a pacemaker ☐a defibrillator (ICD) ☐cardiac stents ☐an artificial heart valve			Please bring your implant card if possible.
Do you have high blood pressure or take medication for high blood pressure?			
Does climbing one flight of stairs or walking one city block make you short of breath?			
Do you have: ☐COPD ☐bronchitis ☐emphysema ☐asthma FORM#OR0002M4 04/23 NUBROI			If yes, do you use inhalers? ☐Occasionally ☐Regularly ☐None

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QUESTION	YES	NO	COMMENTS
Have you been diagnosed with, or are suspected of having, obstructive sleep apnea?			
Do you regularly use a CPAP machine for sleep apnea?			☐I have been told to use a CPAP machine, but do not.
Do you, or have you ever smoked/vaped? *If yes*, what do you smoke/vape? _____			Number per day: _____ Number of years: _____ Year stopped/quit: _____
Do you consume cannabis/marijuana products?			
Do you use recreational drugs or street drugs? If yes, please comment the type and amount.			
Do you drink alcohol?			If yes, how many drinks: Daily: ____ Weekly: ____ ☐ Occasionally
Do you have liver disease, or a history of jaundice or hepatitis?			
Do you have indigestion, heartburn, or a hiatus hernia?			
Do you have a history of thyroid problems?			
Do you have diabetes? ☐Type 1 ☐Type 2 ☐Gestational			If yes, how is it managed? ☐Diet ☐Insulin ☐Oral Medication
Do you have any kidney problems?			
Do you have numbness or weakness of your arms or legs? If yes, please explain in comments.			
Have you ever had: ☐epilepsy ☐ seizure(s)?			If yes, when was your last episode?
Have you ever had a stroke or TIA?			If yes, when?
Have you ever had any problems with blood clots, or excessive bleeding?			If yes, please explain:
Do you have neck or jaw pain or arthritis?			
Have you taken prednisone, steroid medications, or cortisone like drugs in the past year?			
Would you refuse a blood transfusion as a life-saving procedure?			
Do you have any other illnesses, limitations, or any other concerns we should know about?			

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DO YOU TAKE ANY MEDICATIONS?
(Example: oral medications, inhalers, cream, patches, drops, vitamins, or herbal supplements)?
☐ Yes, I take medications. ☐ No, I do not take any medications.

If YES, Please bring ALL your current medications in their original containers AND this completed form with you to your procedure, surgery and pre-anaesthetic appointment(s).

Medication Name and Dose or Strength		**When do you take your medications and how much or how many?**						PLEASE COMPLETE THIS COLUMN ON THE DAY OF YOUR PROCEDURE OR SURGERY
Medication Name	**Dose or Strength**	**AM**	**NOON**	**PM**	**Night**	**Other**	**As Needed**	**Date & Time of Last Dose**

If you require more space, please use a blank piece of paper and attach it with this form.
FAMILY PHYSICIAN/OFFICE/CLINIC _____

PHARMACY NAME AND PHONE NUMBER _____

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PROCEDURE/OPERATION HISTORY What procedures/operations have you had in the past?

PROCEDURE/OPERATION (Please list the most recent first)	YEAR	PROCEDURE/OPERATION	YEAR

ANY ALLERGIES?

ALLERGIC TO	REACTION (examples: anaphylactic, rash, skin irritation)

WHAT IS YOUR CURRENT:
HEIGHT:_____(feet/inches) OR_____(cm) **WEIGHT**:_____(lb) OR_____(kg)

PLEASE COMPLETE THE FOLLOWING ON THE DAY OF YOUR PROCEDURE/SURGERY:

QUESTION	YES	NO	DETAILS
Do you have dentures?			
Do you have veneers, caps, crowns, or bridges?			
Do you have any loose teeth?			
Do you wear glasses or have contact lenses in?			
Do you have hearing aids?			
Do you have any jewellery on or piercings in?			
Do you have implants in your body (including joint replacements, plates, pins, screws) or prosthesis?			
Do you wear a Medic Alert tag?			
Is there any possibility you may be pregnant?			
When was the last date and time you had anything to eat?			
When was the last date and time you had anything to drink?			

Patient Questionnaire completed by:
Name: _____ Signature: _____

☐Patient ☐Family Member ☐Health Care Provider ☐other (specify):
FOR NURSING STAFF – Patient Questionnaire Reviewed by:

Name: _____ Signature:_____

Date (YYYY/MM/DD): _____/_____/_____