CHU de Québec Université Laval

DT1607

PREOPERATIVE
PATIENT QUESTIONNAIRE

PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE AS SOON AS POSSIBLE TO AVOID ANY DELAY IN YOUR SURGERY

☐ **CHUL** Preoperative Clinic, G-1238 Fax : 418 654-2115	**L'Hôtel-Dieu de Québec** ☐ Preoperative Unit, Fax : 418 691-5437 ☐ CRECO Dermatology-Oncology Fax : 418 691-2975	**Hôpital du St-Sacrement** ☐ Preoperative Clinic, K-304 Fax : 418 682-7732 ☐ Preoperative Clinic Centre Universitaire d'opthalmologie (CUO), Fax : 418 682-7578	☐ **Hôpital de l'Enfant-Jésus** Preoperative Clinic, J-2000 Fax : 418 649-5675 ☐ **Hôpital Saint-François d'Assise** Intake Unit, C3-620 Fax : 418 525-4313

Surgeon: _____ Proposed surgery: _____

Age: _____ years Gender: ☐ M ☐ F Weight: _____ kg or _____ pounds Height: _____ m

Assessed by nurse: BMI: _____ kg/m^2 BP: _____ mmHg Pulse: _____ /min RR: _____ /min Saturation: _____%

Allergie(s): ☐ No ☐ Yes Specify: _____ _____ Reaction: _____	**Past surgerie(s):** ☐ No ☐ Yes Specify: _____ _____ _____	**Medical history** (Health problems): ☐ No ☐ Yes Specify: _____ _____ _____

Name of your family doctor: _____ Clinic: _____ Phone : _____

Name of your drugstore: _____ Phone: _____ ☐ Pharmaceutical profile (patient chart)

I authorize my drugstore to fax my pharmaceutical profile (list of medication) to the Clinique d'investigation préopératoire du CHU de Québec.

Name: _____ **Signature:** _____ **Date: (yyyy/mm/dd)** ____/____/____

Please list all of the prescribed medication you are using, including insulin, aerosol or supplements. If you are using **more than 3**, please ask your pharmacist to fax us a list at the above-mentioned number. _____ _____ _____	Please list all of the non-prescribed medication or herbal remedies you are using. _____ _____ _____ _____ _____	Please list all ointments and drops medications you are using. _____ _____ _____ _____ _____

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Nom : Prénom : # Dossier :

	No	Yes	Specify
ANESTHESIA			
1. Have you ever had a general anesthesia?	☐	☐	
2. Have you ever had any problems with anesthesia?	☐	☐	
3. Have any members of your family ever had severe adverse reactions to anesthesia?	☐	☐	
4. Do you wear dental prostheses?	☐	☐	☐ Lower ☐ Upper
5. Do you have any loose or brittle tooth, tooth crown or dental implants?	☐	☐	
6. Do you have problems moving your neck or opening your mouth?	☐	☐	
7. Do you have spinal cord problems? Do you suffer from arthritis, rheumatoid polyarthritis, arthrosis or ankylosing spondylitis? If so, specify the location and the limitations: _____	☐	☐	
RESPIRATORY SYSTEM			
1. Are you under the care of a respirologist?	☐	☐	Name: _____
2. Do you have respiratory problems? ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Other: _____	☐	☐	
3. Have you been diagnosed by a doctor with sleep apnea? If so, do you use breathing support equipment to sleep at night?	☐	☐	Type of equipment:
4. Do you snore loud enough to be heard through a closed door?	☐	☐	
5. Are you often tired or fatigued, or do you frequently fall asleep during the day?	☐	☐	
6. Has anyone observed that you gasp or stop breathing during your sleep?	☐	☐	
CARDIAC SYSTEM			
1. Are you under the care of a cardiologist?	☐	☐	Name: _____
2. Do you suffer from high blood pressure? If so, are you being treated?	☐	☐	
3. Do you suffer from any heart problems? If so, specify: ☐ Angina ☐ Myocardial infarction ☐ Arrhythmia ☐ Heart failure ☐ Pulmonary edema ☐ Heart murmur ☐ Congenital abnormality ☐ Cardiac valves problems ☐ Other: _____	☐	☐	
4. Do you have chest pain when at rest or during physical activity?	☐	☐	
5. Have you ever been examined for chest pain?	☐	☐	
6. Do you become of breath easily or in an abnormally?	☐	☐	
7. Have you ever had any of the following diagnostic test? **If so, specify year and location:** ☐ Electrocardiogram (EKG) _____ ☐ Coronary catheterization _____ ☐ Echocardiogram _____ ☐ Treadmill _____ ☐ Stress-echo / Dobutamine echo _____ ☐ Persantine MIBI stress test (nuclear medicine) _____	☐	☐	
8. Have you ever had a coronary bypass or dilatation with or without coronary stents? **If so, specify year and location**: _____	☐	☐	
9. Do you have a pacemaker? **If so, when and where was it last checked**? _____	☐	☐	
NEUROLOGICAL SYSTEM			
1. Are you under the care of a neurologist?	☐	☐	Name: _____
2. Have you ever had neurological problems? ☐ Multiple sclerosis ☐ Epilepsy ☐ Loss of consciousness ☐ Muscular dystrophy ☐ Seizures ☐ Cerebral palsy ☐ Paralysis ☐ Weak limb ☐ CVA ☐ Loss of vision ☐ Spina bifida	☐	☐	

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RENAL SYSTEM			
1. Are you under the care of a nephrologist?	☐	☐	Name: _____
2. Have you ever had renal problems? ☐ Infections ☐ Calculosis (kidney stones) ☐ Renal failure ☐ Other: _____	☐	☐	
3. Do you receive hemodialysis treatments? When? _____	☐	☐	
ENDOCRINOLOGY			
1. Are you under the care of an endocrinologist or an internist?	☐	☐	Name: _____
2. Do you suffer from diabetes? If so, specify how it is treated: ☐ Diet ☐ Insulin ☐ Oral hypoglycemic (pills)	☐	☐	
3. Do you have problems with your thyroid gland?	☐	☐	
4. Have you taken corticosteroid pills (e.g., prednisone-cortisone) for more than 3 weeks in the past 6 months?	☐	☐	
HEMATOLOGY			
1. Are you under the care of a hematologist (blood specialist)?	☐	☐	Name: _____
2. Have you ever experienced abnormal bleeding episodes while at the dentist, from minor wounds or from surgeries?	☐	☐	
3. Do you suffer from anemia? Do you have personal or family history of thalassemia or sickle-cell anemia? If so, specify:_____	☐	☐	
4. Do you have hereditary coagulation disorders? ☐ Von Willebrand ☐ Hemophilia ☐ Leiden ☐ Other: _____	☐	☐	
5. Have you ever had phlebitis or pulmonary embolism?	☐	☐	
6. If absolutely necessary, would you refuse a blood transfusion?	☐	☐	If so, specify :
7. Have you ever had a blood or blood product transfusion?	☐	☐	
8. Have you ever had an abnormal reaction to blood products?	☐	☐	If so, specify:
DIGESTIVE SYSTEM			
1. Are you under the care of a gastroenterologist?	☐	☐	Name: _____
2. Have you ever had ulcer problems? Do you suffer from gastrorrhagia?	☐	☐	
3. Do you suffer from gastric reflux?	☐	☐	
4. Do you suffer from hepatic cirrhosis?	☐	☐	
HABITS			
1. Do you drink alcohol? If so, how much per day _____ per week _____ If you had an addiction in the past, when did you quit? _____	☐	☐	
2. Do you use “street” drugs or narcotics? If you had an addiction in the past, when did you quit? _____	☐	☐	
3. Do you smoke cigarettes? If so, how many per day _____ If you quit, when did you quit? _____	☐	☐	

Nom : Prénom : # Dossier :

	No	Yes	Specify
INFECTION CONTROL			
1. Are you a carrier of multi-resistant bacteria? (SARM, ERV, etc.)	☐	☐	
2. Are you a carrier of a chronic infection, such as hepatitis or HIV? If so, specify: _____	☐	☐	
WOMEN SPECIFIC QUESTIONS			
1. Have you been in menopause for more than one year? Have you ever had a hysterectomy or a tubal ligation?	☐	☐	
2. Is there any chance you could be pregnant?	☐	☐	
PSYCHOLOGICAL			
1. Are you under the care of a psychiatrist?	☐	☐	Name: _____
2. Do you suffer from mental health problems? ☐ Depression ☐ Anxiety ☐ Bipolar disorder ☐ Schizophrenia ☐ Intellectual disability ☐ Autism ☐ Other: _____	☐	☐	
ADL-DA			
1. Do you live alone? Specify: ☐ Home ☐ CHSLD ☐ Private nursing home with services ☐ Without services Name of nursing home or CHSLD: _____	☐	☐	If stairs, specify number of steps Inside: _____
2. Do you receive services from CLSC? If so, which: _____	☐	☐	Outside: _____
MISCELLANEOUS			
1. Do you have hearing problems? If so, specify on what side.	☐	☐	☐ Right ☐ Left
2. Do you wear a hearing aid? If so, specify on what side.	☐	☐	☐ Right ☐ Left
3. Do you have vision problems? ☐ Cataract ☐ Glaucoma ☐ Other: _____	☐	☐	☐ Glasses ☐ Contact lenses
4. Do you have skin problems? ☐ Open wound ☐ Psoriasis ☐ Zona ☐ Eczema	☐	☐	
5. Do you suffer from urinary incontinence?	☐	☐	
6. Do you have a urinary stoma?	☐	☐	
7. Do you have chronic urinary tract infections?	☐	☐	
8. Do you feel burning or pain when you urinate?	☐	☐	
9. Do you suffer from bowel incontinence?	☐	☐	
10. Do you have an intestinal stoma?	☐	☐	
11. Do you suffer from osteoporosis?	☐	☐	
12. Do you follow a special diet?	☐	☐	
13. Have you involuntarily lose weight in the past 3 months? ☐ More than 5 pounds (2.5 kg) ☐ More than 10 pounds (5 kg)	☐	☐	
14. Have you experienced an unexplained loss of appetite in the past 3 months?	☐	☐	
15. Do you have digestive problems? ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation	☐	☐	
DISCHARGE PLANNING			
1. In general, do you have concentration and/or memory problems?	☐	☐	
2. Do health problems limit you in your activities or cause you to stay home?	☐	☐	
3. Do you regularly need assistance from someone at home? If so, specify: ☐ Hygiene ☐ Cleaning ☐ Meals	☐	☐	
4. Do you need a walking aid? If so, which: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches	☐	☐	
5. Can you rely on a relative or close relation if needed? ☐ Daytime ☐ Evening ☐ Night	☐	☐	
6. Does your surgery or return home make you anxious?	☐	☐	

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CONTACTS THAT WILL HELP YOU AFTER YOUR SURGERY

Name: _____ Relationship: _____ Phone (home) :_____ Phone (work) : _____

Name: _____ Relationship: _____ Phone (home) :_____ Phone (work) : _____

Where are you planning to go after the surgery?

☐ Home ☐ Convalescent home : _____

☐ Other (specify address if different from your residence) : _____

Is there any other information about your health you would like to disclose?

_____

_____

Name : _____ First name : _____ Date of birth : _____/____/____
yyyy mm dd

Signature of patient or respondent : _____ Date : _____/____/____

Name of respondent, if applicable : _____ Relationship : _____ yyyy mm dd

Validation of the questionnaire by nurse : _____ Date : _____/____/____
yyyy mm dd

SECTION RESERVED FOR NURSING STAFF

Discharge planning follow-up ☐ None ☐ Resource list given ☐ List of convalescent homes given
☐ Therapeutic nursing plan ☐ Other : _____

PREOPERATIVE QUESTIONNAIRE UPDATE	NO	YES	SPECIFY
1. Have you experienced changes in your health condition?	☐	☐	
2. Have you consulted a physician?	☐	☐	
3. Has your medication been modified?	☐	☐	
4. Have you developed new allergies?	☐	☐	
5. Do you wish to keep the same contacts that you listed in the questionnaire?	☐	☐	
Is there any other information about your health you would like to disclose?			

Nurse's signature: _____ Date _____/____/____