nova scotia health authority

Same Day Surgery Program

Patient Health History Questionnaire

Patient Name: _____Date of birth:_____yyyy /_____mm/_____ dd
height_____ weight _____
Who completed this form? Patient ☐ Other ☐ Date completed: _____ yyyy/mm/dd
If Other, Name & Relationship to patient: (please print) _____

Do you have a responsible adult to accompany you home and stay with you after Day Surgery (Outpatient Surgery)?
YES ☐ NO ☐ If you answered NO, you must make these arrangements or your surgery will be cancelled.

1. Do you smoke? YES ☐ NO ☐ How many per day?_____ Number of years you have smoked? _____
2. If you stopped smoking when did you quit? _____
3. Is it possible you are pregnant? YES ☐ NO ☐
4. Do you take Warfarin, Coumadin, Aspirin, Plavix or any other blood thinner? YES ☐ NO ☐
5. Have you taken oral or IV Prednisone, Cortisone or steroids (excluding inhalers and creams) in the past 12 months? YES ☐ NO ☐

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO
6. a) An unusual or serious reaction or complication to any kind of anesthetic?	☐	☐
b) Has this happened to anyone else in your family?	☐	☐
7. Nausea or vomiting after an anesthetic?	☐	☐
8. Difficulty with neck movement or opening your mouth? Do you have a neck injury?	☐	☐
9. Capped, loose, false teeth or body piercing?	☐	☐
10. Hiatus hernia or significant problems with stomach acid or heartburn?	☐	☐
11. Asthma, bronchitis, COPD, TB?	☐	☐
12. Are you on home oxygen?	☐	☐
13. Chronic or troublesome cough?	☐	☐
14. Shortness of breath at rest or when lying flat?	☐	☐
15. Shortness of breath climbing one flight of stairs?	☐	☐
16. Do you have sleep apnea ?	☐	☐
17. Do you use a CPAP machine ?	☐	☐
18. Do you snore loudly?	☐	☐
19. Are you extremely tired during the day?	☐	☐
20. Has anyone observed that you choke, gasp or stop breathing during sleep?	☐	☐
21. Do you have high blood pressure?	☐	☐
22. Heart problems such as:		
a) Heart murmur?	☐	☐
b) Valve replacement surgery?	☐	☐
c) Palpitations, skipped heartbeat?	☐	☐

	YES	NO
23. Pacemaker or implantable cardioverter-defibrilator(ICD)	☐	☐
24. Angina, heart attack or cardiac stent?	☐	☐
25. Chest pressure or pain with exercise?	☐	☐
26. Heart testing such as:		
a) Stress test (treadmill test)?	☐	☐
b) Dye Test / Cardiac Catheterization?	☐	☐
27. Bruise or bleed easily (you or your family)?	☐	☐
28. Leg or lung blood clots or DVT?	☐	☐
29. Current low blood count, current anemia or other blood disorder?	☐	☐
30. Blackouts or fainting spells in the last year?	☐	☐
31. Stroke, mini stroke, severe muscle weakness or paralysis of any part of your body?	☐	☐
32. Epilepsy, seizure or a significant neurological disorder?	☐	☐
33. Kidney disease?	☐	☐
34. Thyroid problems?	☐	☐
35. Diabetes?	☐	☐
36. Rheumatoid arthritis? (not Osteoarthritis)	☐	☐
37. HIV?	☐	☐
38. Yellow jaundice, hepatitis or liver problems? When?	☐	☐
39. Do you have one of these IV lines?		
a) PICC line ☐	☐	☐
b) Port-a-cath ☐	☐	☐

PLEASE FILL OUT FRONT AND BACK OF THIS FORM

40. Have you been found to have an antibiotic resistant organism like MRSA or VRE? YES ☐ NO ☐

41. Have you or any family members been diagnosed with CJD (Mad Cow Disease) or told you may be a carrier of the disease? YES ☐ NO ☐

42. Do you have chronic or acute pain requiring prescription medication? YES ☐ NO ☐

43. Do you drink alcohol, wine or beer? YES ☐ NO ☐
How much? _____ How often? _____

44. Do you use street / recreational drugs? YES ☐ NO ☐
Type_____ How often? _____

45. List any major illnesses (including psychological)
_____
_____
_____

46. List any operations you have had – include where and when you had the operation.
_____
_____
_____

47. When was the last time you were in hospital _____Where?_____
Why? _____

48. When was the last time you had a general anesthetic? _____ What hospital?_____

49. **Are you allergic to LATEX?** YES ☐ NO ☐ what is your reaction? _____

50. **Do you have any other allergies?** YES ☐ NO ☐ **Please list all allergies and your reaction**

Allergic to:	**Reaction:**	**Allergic to:**	**Reaction:**

51. Do you take any medications? YES ☐ NO ☐ If yes, list all medications below: all prescriptions, insulin, herbals and over the counter medication.

Medication	**Dose and when taken**	**Medication**	**Dose and when taken**

Pharmacy name_____ ***location***_____ ***Phone #***_____

If you have significant changes to your health before your surgery, please contact your surgeon's office.

Reviewed by: RN Signature _____/_____
yyyy/mm/dd