part of the Vancouver Coastal Health Authority

PRE-OPERATIVE PATIENT HEALTH QUESTIONNAIRE

PCIS LABEL

DATE:_____

Patient Name _____ D.O.B_____PHN_____

This patient Questionnaire is being completed by: ☐ Patient ☐ Support Person/Family Member ☐ Healthcare provider

If NOT completed by patient, please give explanation why_____

Dear Patient,

This is a very important document for you to complete before you have surgery. The VGH Pre-Admission Clinic will use the information you provide to determine your surgical care needs.

This comprehensive questionnaire asks lots of questions about your medical history to ensure that the clinic can safely assess your surgical risks, as well as help prepare you for surgery.

Please complete this form as best you can before returning it to your Surgeon's office. If you are not sure what a question means, please add as much detail as you can and you will be asked for more information at your pre-admission appointment. There is extra writing space at the end of the Questionnaire, if needed.

Please place an 'X' in either the No or Yes column for each question below where indicated.

Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
1. ANESTHESIA				
Any surgical procedure under general anesthesia, spinal, epidural, nerve block, or local anesthesia?			List procedure name, where and when. Expand on last page if needed.	
Personal history of problem with anesthesia?			What / Where / When	
Blood related family member with a history of serious problem with anesthesia?			What	
Admitted to hospital or visits to the emergency department in the past year?			List reason, which hospital and when: Please expand on last page if needed.	
2. FUNCTIONAL STATUS				
How much difficulty do you have in lifting and carrying 10 pounds?	None = 0 ☐	Some = 1 ☐	A Lot or Unable = 2 ☐	
How much difficulty do you have walking across a room?	None = 0 ☐	Some = 1 ☐	A Lot, use aids, or unable = 2 ☐	
How much difficulty do you have transferring from a chair or bed?	None = 0 ☐	Some = 1 ☐	A Lot, or unable without help = 2 ☐	
How much difficulty do you have climbing a flight of 10 stairs?	None = 0 ☐	Some = 1 ☐	A Lot or Unable = 2 ☐	

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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
How many times have you fallen in the past year?			None = 0 ☐ Some = 1 ☐ A lot = 2 ☐ If you have fallen in the past, what caused the fall(s) _____ _____	**Total Score___**
How often do you engage in activities that are light to moderately strenuous? (eg. going for a walk, jogging, gardening, dancing)?			Once a week or less ☐ More than once a week ☐ Within that week, on average how many times? _____ On average how many minutes each time? _____	
Do you use a mobility aid such as wheelchair, walker, cane, or scooter?			If yes, what is the reason? _____ _____	
Do you require assistance with activities of daily living? (eg. personal hygiene, dressing, feeding, ambulating)?			If yes, what form of assistance do you have? _____ _____	
Problems with hearing?			Hearing aids? ☐ Specify _____	
Problems with eyesight?			Specify _____ _____	
3. BREATHING / RESPIRATORY				
Obstructive sleep apnea (stop breathing while asleep) diagnosed by Sleep Study?			If yes: Date and where?_____ Was the Sleep Study done in Sleep Lab ☐ or Home Sleep Study ☐ Do you use a CPAP machine? Yes ☐ No ☐ Tried CPAP but not using regularly ☐	
Asthma, emphysema, chronic bronchitis, or chronic obstructive pulmonary disease (COPD)?			If yes: Have you previously sought urgent or emergent care for your breathing? Yes ☐ No ☐ Oral steroid in the past year? Yes ☐ No ☐	
Home oxygen use?			If yes: Do you use all the time? Yes ☐ No ☐ Do you use only at night? Yes ☐ No ☐ L/min_____	
Shortness of breath with normal activity or lying flat?				
Have you been seen by a Lung Specialist (Respirologist) in the past 5 years?			Name of Specialist Doctor_____ Where and when_____ _____	
Lung (pulmonary) function test (PFT) in the past 5 years?			Where and when _____ _____	

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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
Any other breathing or lung condition?			Describe _____	
4. HEART / CARDIOVASCULAR				
High blood pressure?				
Do you take medication to treat your blood pressure?				
Any heart related symptoms at rest or with physical activity?:				
• Chest pain, pressure, discomfort			What brings it on/triggers _____	
• Shortness of breath or breathlessness			What brings it on/triggers _____	
• Palpitations or irregular heartbeats			What brings it on/triggers _____	
• Fainting or blackout			What brings it on/triggers _____	
Any known heart related problem?:				
• Heart murmur				
• Angina, heart attack, heart surgery, angioplasty, stent			If yes, when and where were you treated or had your operation _____	
• Heart valve problem (including repair, replacement or leaking)			Please describe your valve issue _____ Please provide details, of any previous operations_____	
• Weak Heart (e.g Heart failure, CHF)			How many years? _____ Who manages your heart failure?_____	
• Pacemaker or defibrillator (ICD)?			Please specify type of device_____ When was it implanted and why? _____ Location of implant _____ When was its function last tested? Which clinic manages your pacemaker? Please provide a copy of your pacemaker card.	
Any known vascular problem?:				
• Peripheral vascular disease (blood flow problem in arms or legs)			Please describe the nature of your condition_____	
Any one of the following tests in the past 5 years?:				
• Followed by a Cardiologist			Name _____	
• Exercise stress test (treadmill)			When, where_____	

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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
• Nuclear medicine heart scan (e.g Myocardial Perfusion Imaging Test- MIBI)			When, where_____	
• Heart or coronary catheterization (angiogram)			When, where_____	
• Heart echo test (ultrasound)			When, where_____	
• Holter monitor			When, where_____	
Any other heart related conditions?			Describe_____	
5. NEUROLOGICAL				
Do you have any memory problems?			Please explain _____	
Have you been diagnosed with dementia?			Known MMSE or MOCA Score?_____	
Do you get confused or disorientated?			What were the circumstances? _____	
Disease affecting muscles and nerves?			Details: _____	
Stroke, "mini-stroke" or transient ischemic attack (TIA) in the past?			When? _____ Permanent deficits? _____ Please detail any ongoing effects?_____	
Traumatic brain injury that continues to affect your function?			When? _____ Effect on function: _____	
Spinal cord injury?			Injury level _____ Any autonomic dysreflexia Yes ☐ No ☐ Paraplegia ☐ Quadriplegia ☐ Spine surgery date _____ Tracheostomy? Yes ☐ No ☐ Ventilatory Supports such as CPAP, BIPAP, Home Ventilator? Yes ☐ No ☐	
Have you had epilepsy, convulsions, or seizures in the past?			Date of last seizure _____	
Have you been seen by a Neurologist in the past 5 years?			Name _____ Where and when _____ Type of condition if not mentioned above: _____	

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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
Do you have mental health concerns such as anxiety, mood disorders, post-traumatic stress disorder, psychosis, or phobias?			If yes, are you worried about worsening symptoms during or after hospitalization? Yes ☐ No ☐	
6. BLOOD PROBLEMS / HEMATOLOGICAL				
Daily aspirin / ASA usage?			Reason _____	
Prescription of blood thinner? ☐ Plavix (clopidogrel) ☐ Brilinta (ticagrelor) ☐ Coumadin (warfarin) ☐ Xarelto (rivaroxaban) ☐ Pradaxa (dabigatran) ☐ Eliquis (apixaban) ☐ Heparin, low molecular weight heparin (eg. dalteparin, enoxaparin) ☐ Other _____			Reason for medication:_____ Do you have instructions on managing this medication at the time of surgery? Yes ☐ No ☐ What instructions have you been given by your healthcare provider? _____ _____ _____ _____	
Have you been told by a medical doctor that you have a bleeding disorder (not including blood thinner medications)?			If yes, what kind do you have? Hemophilia ☐ Von Willebrand disease (vWD) ☐ Other:_____	
Have you been seen by a Hematologist (blood doctor) in the past 5 years?			Reason _____ Name_____ Where and when _____	
An advanced directive refusing blood transfusion?			Reason for refusal _____ _____	
Have you been told by a health care professional that you have special blood requirements such as:				
a) Blood antibodies or given a special antibody card to carry?				
b) Irradiated blood?			Reason and Ordering Physician (who told you that you needed irradiated blood) _____	
c) IgA deficiency?				
Have you been transfused with red cells or platelets in the last 90 days?				
Are you pregnant or have been within the last 90 days?				

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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
7. NUTRITION				
Have you lost weight in the past 6 months WITHOUT TRYING to lose weight?				
Have you been eating less than usual FOR MORE THAN ONE WEEK?				
8. SUBSTANCE USE				
Have you used nicotine product within the last six months? (e.g smoking, vaping)?			Type _____ If not currently, when did you quit?_____ Would you like help to stop smoking? Yes ☐ No ☐	
If no to previous question, were you a regular cigarette smoker in the past?			If yes: How many years did you smoke for?_____ In what year did you stop smoking? _____	
Have you used cannabis product within the last six months? (including oils, edibles)			Type_____ Amount per week _____	
Do you consume alcohol?			Type _____ Number of drinks per week _____ How many times in the last year have you had 4 or more drinks (if female) or 5 or more drinks (if male), on one occasion? _____	
Do you use other recreational drugs?			Type _____ Route: Oral ☐ Injection ☐ Inhale ☐ Amount per week _____ Are you on an opioid agonist therapy? Yes ☐ No ☐	
9. CHRONIC PAIN				
Do you have chronic pain?			If yes, where do you experience pain? _____	
Have you ever had a bad experience with postoperative pain management or use of opioid for pain management?			If yes, please explain: _____ _____ _____	
Have you ever been seen by a hospital-based complex pain service, outpatient chronic pain clinic, or transitional pain clinic?			If yes, When _____ Where_____	
In thinking about your pain, how much do you agree with the statements on the right? Please answer in a scale of 0 to 4. 0 = not at all 1 = to a slight degree 2 = to a moderate degree 3 = to a great degree 4 = all the time	Statements: • It's awful and I feel that it overwhelms me. _____ • I can't keep it out of my mind. _____ • I keep thinking how much it hurts. _____ • I keep thinking how badly I want the pain to stop._____			**Total Score___**

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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
How intense has your pain been on average over the past **week**?	Please rate your pain by circling the one number that best describes your pain on AVERAGE: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE			**Rating____**
Do you use opioids or narcotics for managing your pain?			Name, dose, frequency_____ _____ _____ Prescriber_____ Do you want help reducing your opioid pain medications prior to surgery? Yes ☐ No ☐	
Do you use non-opioids or non-narcotic medications for managing your pain?			Please list any medications in the medication box on page 9	
10. OTHER MEDICAL PROBLEMS				
Diabetes?			How it is controlled: Diet ☐ Pills ☐ Insulin ☐ Last known HbA1C _____ Have you had any complications? (eg. eyes, neuropathy, kidney disease, foot ulcer) Yes ☐ No ☐	
Kidney disease?			Dialysis – route, schedule_____ _____ Other_____	
Do you have any problems passing urine?			Reason_____ _____	
Do you have a urinary catheter?			Indwelling urethral ☐ Suprapubic ☐ Intermittent self-catheterization ☐	
Do you have any problems with your bowels?			Reason_____ _____	
Liver disease (eg. hepatitis, cancer, cirrhosis)?			If yes, what is the diagnosis? _____ _____	
Solid organ transplant?			Which organ?_____ When? _____	
Arthritis?			Osteoarthritis ☐ Rheumatoid arthritis ☐ Ankylosing spondylitis ☐ Arthritis affecting neck / cervical spine ☐ Other_____	

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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
Infections? (Tick the box of any that apply): • HIV ☐ • Hepatitis B or C ☐ • Recent or current cold, chest infection, or fever ☐ • Herpes with lesions or Shingles with lesions ☐ • Exposure to: Measles ☐, Mumps ☐, Varicella ☐ in past 2 weeks • MRSA, VRE ☐ • UTI ☐ • TB (active) ☐ • TB (exposure to in past 2 months) ☐ • Other _____			Treatment _____ Did you have complications from disease or treatment? Yes ☐ No ☐ Have you had a resistant bacteria that required isolation? Yes ☐ No ☐ If yes, which one _____ If chest infection: • When _____ • Current symptoms _____ • Did you have a COVID test and what was the result _____	
In the last 12 months, have you been admitted to a hospital in Fraser Health Authority Acute Care overnight or admitted overnight to a hospital outside of Canada?			Specify where _____ _____ _____ _____ _____	
Do you have any rashes, cuts or open wounds?				
Are you on hormonal birth control?				
Cancer within the last 5 years (other than relating to reason for surgery)?			Location / type _____ Chemotherapy Yes ☐ No ☐ Date of last treatment _____ Radiation therapy Yes ☐ No ☐ Date of last treatment _____ Complications from treatment Yes ☐ No ☐ Where have you had treatment _____ _____ _____ _____	
Vascular access device (IVAD, PICC, Portacath)?			Specify device_____ What is it normally flushed with?_____	
Autoimmune disease? (e.g Lupus, M.S)			Diagnosis, if known_____ Does it affect heart, lungs, kidneys, liver, blood clotting, skin? Yes ☐ No ☐	
Any other medical problems not already mentioned?			Please expand if yes: _____ _____ _____ _____	

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Do you have, or have you ever had, any of the following?	NO (X)	YES (X)	If the answer is 'YES' or you are not sure, please provide details.	STAFF USE ONLY
11. MEDICATIONS				
Do you take any medications? (Including prescription, over the counter, supplements, vitamins and/or herbal)			Please list all the medications that you take: Name, dose and frequency (Attach a list if necessary or use space at end of Questionnaire) _____ _____ _____ _____ _____ _____	
12. ALLERGIES				
Do you have any allergies?			Latex ☐ Metal ☐ IV Contrast Dye ☐ Antibiotics ☐ _____ Medications ☐ _____ Food ☐ _____ Other ☐ _____	
13. OTHER INFORMATION				
Do you have a support person/healthcare representative?			Name of support person/representative _____ _____	
What is your living situation?			Home ☐ Care Facility ☐ Homeless ☐ Live Alone ☐ Assisted Living ☐	
Who is picking you up from hospital when you are ready to go home?			Name_____ Number _____	
Do you have a Living Will/Advance Directive?				
Are you using homecare assistance?			Private ☐ Public ☐ Health Authority _____	
Indigenous Community/Nation (if you wish to self identify)			Please specify _____ _____ _____	
Do you speak conversational English?			If no, what language do you speak? _____	
Current Height				
Current Weight			_____kg or lbs (please circle)	BMI _____
Daytime telephone number				
Cellphone				
Email				
Alternate Email				
Next of Kin telephone number				

Signature of person completing the form:

_____

PAC RN	
Signature	
Date	

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EXTRA SPACE IF REQUIRED:

EXTRA SPACE FOR MEDICATION LIST

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