Lions Gate Hospital
part of the Vancouver Coastal Health Authority

PRE-OPERATIVE PATIENT HEALTH QUESTIONNAIRE

LABEL

Name: _____ Phone: _____ Cell: _____

Email: _____ City: _____ Prov: _____

Family Physician: _____ Dr. Phone: _____

DOB: _____ ☐M ☐F Ht: _____ Wt: _____ BMI: _____ OFFICE USE ONLY

HEART				
DO YOU HAVE:	**YES**	**NO**	**NOT SURE**	**COMMENTS**
Any heart problems? (e.g. heart attack, chest pain, heart blockages, stents, valve problems, murmur, irregular heartbeat, heart surgery, heart failure.)	☐	☐	☐	Specify:
High blood pressure?	☐	☐	☐	Well controlled? ☐Y ☐N
Chest pain or breathlessness after climbing 2 flights of stairs?	☐	☐	☐	
A pacemaker or an implantable defibrillator?	☐	☐	☐	
Do you take Aspirin (ASA) regularly?	☐	☐	☐	Why?
A prescription for blood thinners? (e.g. warfarin, clopidogrel, dabigatran, rivaroxaban, apixaban)	☐	☐	☐	Why?
Any other heart issues?	☐	☐	☐	
BREATHING				
DO YOU HAVE:	**YES**	**NO**	**NOT SURE**	**COMMENTS**
Emphysema, chronic obstructive pulmonary disease (COPD), or chronic bronchitis?	☐	☐	☐	
Asthma?	☐	☐	☐	How often do you use ventolin?
A problem lying flat for at least 30min because of difficulty breathing?	☐	☐	☐	
Inhalers (puffers)?	☐	☐	☐	
Oxygen at home to help you breathe?	☐	☐	☐	
Do you smoke? (e.g. cigarettes, cigars, pipe) Do you “vape”?	☐	☐	☐	Number/day: Number of years:
Shortness of breath for which you have been admitted to hospital?	☐	☐	☐	
Do you have any other breathing issues?	☐	☐	☐	
PROBLEMS BREATHING DURING SLEEP				
DO YOU HAVE:	**YES**	**NO**	**NOT SURE**	**COMMENTS**
Sleep apnea?	☐	☐	☐	
A breathing machine to help you sleep?	☐	☐	☐	
Loud snoring?	☐	☐	☐	
Frequent daytime tiredness or fatigue?	☐	☐	☐	
Choking spells or apneas (times when you stop breathing) during sleep?	☐	☐	☐	
BLOOD PROBLEMS				
HAVE YOU EVER BEEN TREATED FOR:	**YES**	**NO**	**NOT SURE**	**COMMENTS**
A bleeding disease or problem?	☐	☐	☐	Specify:
Blood clots (in your legs, lungs, or other)?	☐	☐	☐	Specify:
Do you have any personal or religious reasons for refusing to have any blood products given to you?	☐	☐	☐	

NAME: _____

NEUROLOGICAL

DO YOU HAVE/HAVE YOU HAD:	YES	NO	NOT SURE	COMMENTS
Memory problems or confusion?	☐	☐	☐	
A history of extreme confusion after an operation?	☐	☐	☐	
A disease that affects your muscles and/or nerves?	☐	☐	☐	
A stroke or stroke-like symptoms?	☐	☐	☐	When?
Any aneurysm?	☐	☐	☐	
Epilepsy / seizures / convulsions?	☐	☐	☐	
Fainting spells?	☐	☐	☐	

OTHER IMPORTANT MEDICAL INFORMATION

	YES	NO	NOT SURE	COMMENTS
Have you had serious problems with anesthesia? (e.g. malignant hyperthermia)	☐	☐	☐	
Do you have family (blood relatives) who have had serious problems with anesthesia?	☐	☐	☐	

	YES	NO	NOT SURE	COMMENTS
Do you have trouble opening your mouth, jaw, or moving your neck?	☐	☐	☐	
Do you have chronic pain?	☐	☐	☐	Where on body?
Are you diabetic?	☐	☐	☐	☐ Insulin ☐ Diabetic pills ☐ Diet controlled
Do you have kidney problems?	☐	☐	☐	
Do you have thyroid problems?	☐	☐	☐	
Are you HIV positive?	☐	☐	☐	☐ Treated ☐ Not treated
Have you had Hepatitis B or Hepatitis C?	☐	☐	☐	
Do you have liver problems? (e.g. cirrhosis)	☐	☐	☐	
Have you had an organ transplant?	☐	☐	☐	
Do you have stomach ulcers, heartburn, or hiatus hernia?	☐	☐	☐	
Do you have an autoimmune disease (e.g. lupus, rheumatoid arthritis) or see a Rheumatologist?	☐	☐	☐	
Have you had radiation treatment?	☐	☐	☐	Where on body?
Have you required steroid pills like prednisone in the past year?	☐	☐	☐	
Do you have bipolar disorder or schizophrenia?	☐	☐	☐	
Do you drink alcohol?	☐	☐	☐	How much: How often:
Do you use any recreational drugs?	☐	☐	☐	Which drug(s): How often:
Do you use marijuana / cannabis products?	☐	☐	☐	Form taken: How often:

Do you have any other illness, limitations or any other concerns we should know about? ☐ Yes ☐ No
Specify:

NAME: _____

LIST ANY DRUG ALLERGIES OR INTOLERANCES

DRUG	REACTION

LIST ALL OF THE MEDICATIONS THAT YOU TAKE (INCLUDING HERBAL MEDICATION, VITAMINS, AND NON PRESCRIPTION DRUGS). ATTACH A LIST IF NECESSARY.

LIST ANY SPECIALIST PHYSICIANS YOU HAVE SEEN
E.g. Cardiologist, Respirologist, Endocrinologist, Rheumatologist, Gastroenterologist, Hematologist, Neurologist

WHO	YEAR	WHO	YEAR

LIST ANY SURGERIES USING ANESTHETIC YOU HAVE HAD IN THE PAST

PROCEDURE	YEAR	PROCEDURE	YEAR

Patient Heath Questionnaire completed by:
☐ Patient ☐ Family member ☐ Health care provider ☐ Other:

Print name(s): Signature:

Date (yyy/mm/dd):

IMPORTANT: PLEASE REMEMBER TO LET YOUR SURGEON KNOW IF YOU THINK YOU ARE GETTING A COLD, FLU, OR ILLNESS OR IF YOU START TAKING ANY NEW MEDICATIONS PRIOR TO YOUR SURGERY.