OKANAGAN
Health Surgical Centre

Pre-Operative Screening Questionnaire

Name _____ Contact Number _____

E-mail address _____

Height _____ cm Weight _____ kg

Allergies (*Food, Medicines, Latex*) _____

Current Health History

Cardiac History

	Yes	No	Don't Know
High Blood Pressure	○	○	○
Heart Attack	○	○	○
Angina	○	○	○
Pacemake	○	○	○
Rhythm Problems	○	○	○
Have you ever been treated for blood clots?	○	○	○
Are you on the blood thinning medication Plavix?	○	○	○
Are you on the blood thinning medication Warfarin?	○	○	○
Are you on the blood thinning medication ASA?	○	○	○

Respiratory History

	Yes	No	Don't Know
Asthma	◯	◯	◯
Are you short of breath when walking up two flights of stairs?	◯	◯	◯
Emphysema	◯	◯	◯
Do you use oxygen?	◯	◯	◯
Chronic Obstruction Pulmonary Disease (COPD)	◯	◯	◯
Sleep Apnea	◯	◯	◯
Do you have a machine that helps you breath at night (CPAP)	◯	◯	◯
Recent chest infection (Pneumonia or Bronchitis)	◯	◯	◯
Do you smoke?	◯	◯	◯

Neurological History

	Yes	No	Don't Know
Anxiety	◯	◯	◯
Depression	◯	◯	◯
History of Seizures or Convulsions	◯	◯	◯
Muscular Dystrophy	◯	◯	◯
ALS (Amyotrphic Lateral Sclerosis)	◯	◯	◯
MS (Multiple Sclerosis)	◯	◯	◯

Other Symptoms and History

	Yes	No	Don't Know
Diabetes - Diet control	◯	◯	◯
Diabetes - Pill Controlled	◯	◯	◯
Diabetes - Insulin Dependent	◯	◯	◯
Liver Disease	◯	◯	◯
Jaundice	◯	◯	◯
Hepatitis	◯	◯	◯
Thyroid Problems	◯	◯	◯
Kidney Disease	◯	◯	◯
Rheumatoid Arthritis	◯	◯	◯
Heartburn	◯	◯	◯
Gastric Reflux (GERD)	◯	◯	◯
Ulcer	◯	◯	◯
Hiatus Hernia	◯	◯	◯
Chronic Pain Problems	◯	◯	◯

Anesthesia History

	Yes	No	Don't Know
Have you ever had anesthesia?	◯	◯	◯
Have you ever had any problems with anesthesia?	◯	◯	◯
Has any member of your family had a problem with anesthesia?	◯	◯	◯
History Malignant Hyperthermia	◯	◯	◯

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Surgeon _____ BMI _____

Consult Date _____ Surgical Date _____

Labs sent
- ☐ CBC
- ☐ LYTES
- ☐ ECG
- ☐ X-RY
- ☐ MRI

ETOH USE: How many drinks per day? _____

RECREATIONAL DRUG USE: Kind _____

Amount _____

Last Used _____

SMOKING (Answer Yes): How much per day _____ Quit _____

Pre-Screening RN _____ Pre-Screening Date _____