Vancouver Acute: VGH & UBCH
part of the Vancouver Coastal Health Authority

PRE-ANESTHETIC PATIENT QUESTIONNAIRE

PCIS LABEL

Name: _____

Date of Birth: _____

Date: _____

*After completing **both sides** of this questionnaire, return it to your Surgeon's office assistant -- who will submit it to the hospital as part of your confidential medical record. This information will only be seen by hospital physicians and nurses involved with your care.*

Do you have, or ever had, any of the following?	NO	YES	If the answer is 'YES' to any of the questions, provide details and check the appropriate boxes below
Life threatening problem with anesthesia (includes general, spinal, epidural, nerve block or local anesthesia)?			
Blood related family member with a history of life threatening problem with anesthesia?			
Regular tobacco smoker?			☐ Current ☐ Past - year quit _____ Cigarettes / day _____ Years smoking _____ ☐ I cough up phlegm in the morning
Regular alcohol usage?			Type _____ Amount per week _____
Regular recreational drug usage?			Type _____ Amount per week _____
Regular severe heartburn or acid reflux?			
Current difficulty opening your mouth or bending your neck?			
Obstructive sleep apnea (stop breathing while asleep)?			☐ CPAP prescribed ☐ Sleep study: When? _____
Shortness of breath with normal activity such as walking or climbing stairs?			If yes, state after how many paces/blocks, or steps/flights of stairs
☐ Asthma or ☐ Emphysema ?			
Have you been seen by a **Respirologist** in the past 5 years?			Name: _____ Where and when: _____
Have you had a lung (pulmonary) function test in the past 5 years?			Where and when:
Irregular heartbeats or palpitations?			☐ Atrial Fibrillation ☐ Other:
Fainting or blackouts?			Frequency and last occurrence:
High blood pressure?			
Heart related chest pain / angina?			Heart attack? ☐ No ☐ Yes: Date _____
Heart surgery or angioplasty?			Type and year: _____
Pacemaker?			Follow up clinic / doctor _____
Heart murmur?			☐ Testing: what and when _____
Heart valve problems?			
Have you been seen by a **Cardiologist** in the past 5 years?			Name: _____ Where and when: _____
Have you had one of the following heart tests in the past 5 years?			**If yes, list where and when below:**
Exercise stress test (treadmill)			
Nuclear medicine **heart** scan (MIBI)			
Heart catheterization (angiogram)			
Heart echo test (ultrasound)			
Holter monitor			

Do you have, or ever had, any of the following?	NO	YES	If the answer is 'YES' to any of the questions, provide details and check the appropriate boxes below
Stroke or Transient Ischemic Attack / "warning" stroke?			When:_____
Spinal cord injury?			☐ Paraplegic ☐ Quadraplegic - Level:_____ ☐ Spine Surgery – Location on spine _____
Epilepsy or seizures?			Date of last seizure:
Have you been seen by a **Neurologist** in the past 5 years?			Name: _____ Where and when: _____
Diabetes?			
Liver problems, jaundice or hepatitis?			When:_____
Kidney problems?			☐ Dialysis – Schedule: _____ ☐ Transplant ☐ Other _____
Bleeding disorders or blood clotting problems?			☐ Hemophilia ☐ Other
Refusal to receive blood products?			☐ Jehovah's Witness
Blood borne or other infectious illnesses?			Details:
Diagnosed with rheumatoid arthritis? (not osteoarthritis)			
For female patients: Are you pregnant?			
Any other medical problems not already mentioned?			Details:

Are you on any **medications?** ☐ None

Name of medication	Dosage	How Often?

☐ This space is insufficient , a separate list is attached

If on **pain medication**, indicate the maximum dose that you have taken in one day in the last month?

Name of medication	Maximum total amount in 24 hours

Latex allergy ☐ No ☐ Yes Metal allergy ☐ No ☐ Yes

Medication allergies will be assessed by your physician

Current Height _____ Current Weight _____

Daytime telephone number: _____

Email: _____

Family doctor Name: Location: Office number:

Do you speak conversational English? ☐ Yes ☐ No If No, what language do you speak:_____

Please note one family member is welcome to attend Pre-operative appointments.

Pharmanet and Pathnet Consent

Pharmanet and Pathnet allow computerized access to the drugs you are taking and the results of laboratory tests that you have had done. To check your current medication and avoid repeating lab tests unnecessarily, we would like your permission to access this information.

My signature authorizes Vancouver Coastal Health authority to access my personal health information recorded elsewhere, for the purpose of providing care and treatment. This includes access to my PharmaNet medication profile and Pathnet laboratory information (BC biochemical, MDS Metro and St. Mary's lab results).
This consent will continue until such time as I revoke this authorization in writing.

Date Authorized	Patient Name (printed)	Patient Signature
_____	_____	_____