Doctor	
Name	
First name	
Date of birth	**Age**
H.I.N.	**Expiration**

PREOPERATIVE QUESTIONNAIRE

Expected surgery (ies) :

Age: Weight: pd/kg	Height: pi/m	BMI: kg/m²	B.P..:	Pulse:

Denture(s), bridges(s),: crown(s): Yes ☐ No ☐	**Hearing aid(s):** Yes ☐ No ☐	**Contact lenses:** Yes ☐ No ☐

Known treated medical condition(s):

_____

_____

Known untreated medical condition (s) :

_____

_____

Previous surgery(ies)

_____

_____

_____

_____

List of medication :

1. _____
2. _____
3. _____
4. _____
5. _____

List of natural products :

1. _____
2. _____
3. _____
4. _____
5. _____

Are you taking:

Anticoagulants ? Yes ☐ No ☐ If so which ones: _____

Aspirin ? Yes ☐ No ☐

Have you ever had anesthesia :

General ? Yes ☐ No ☐

Regional ? Yes ☐ No ☐

Local ? Yes ☐ No ☐

Previous history of nausea and vomiting postoperatively ? Yes ☐ No ☐

During anesthesia, did you, or a member of your family, ever had any complication ?

Yes ☐ No ☐

If so, which ones : _____

PREOPERATIVE QUESTIONNAIRE

Do you have allergies to: **Specify**

Medication: Yes ☐ No ☐ _____
Latex: Yes ☐ No ☐ _____
Food: Yes ☐ No ☐ _____

Do you have food intolerance?
Specify : _____

Lifestyle habits :

Tobacco: Yes ☐ No ☐ **Consumption/daily:** _____

if stopped, since when: _____

Alcool: Yes ☐ No ☐ **Consumption/daily:** _____

Drug(s): Yes ☐ No ☐ **Consommation/frequency:** _____

Vegetarian Yes ☐ No ☐

Vegan Yes ☐ No ☐

Could you possibly be pregrant? Yes ☐ No ☐

In the past 4 weeks, have you had a cold or the flu? Yes ☐ No ☐

Have you taken cortisone orally In the past 12 months ? Yes ☐ No ☐

Have you ever received chemotherapy or radiotherapy treatments ? Yes ☐ No ☐

In the current year, have you been hospitalized for more than 24 hours ? Yes ☐ No ☐

If so, for which reason (s): _____

At which hospital ? _____

Do you have heart related problems ?

Pain (angina) :	Yes ☐	No ☐
Shortness of breath :	Yes ☐	No ☐
Palpitations / arrhythmia	Yes ☐	No ☐
Hypertension (blood pressure) :	Yes ☐	No ☐
Myocardial infarction (heart attack) :	Yes ☐	No ☐
Heart failure :	Yes ☐	No ☐
Valvular disorder (heart murmur) :	Yes ☐	No ☐

Do you have a pacemaker ? Yes ☐ No ☐

If so, what kind **Permanent pacemaker** ☐ **OR** **Defibrillator pacemaker** ☐

PREOPERATIVE QUESTIONNAIRE

Do you have lungs related problems ?

Asthma:	Yes ☐	No ☐
Bronchitis	Yes ☐	No ☐
Pneumonia	Yes ☐	No ☐
Emphysema:	Yes ☐	No ☐
Cough/expectorations (sputum):	Yes ☐	No ☐
Pulmonary embolism:	Yes ☐	No ☐
Sleep apnea:	Yes ☐	No ☐
CPAP/home oxygen:	Yes ☐	No ☐
Tuberculosis:	Yes ☐	No ☐

Do you suffer from neurological problems?

Epilepsy/convulsions:	Yes ☐	No ☐
Paralysis/CVA:	Yes ☐	No ☐
Numbness:	Yes ☐	No ☐
Loss of consciousness:	Yes ☐	No ☐
Migraine:	Yes ☐	No ☐
Back pain:	Yes ☐	No ☐
Neck problems:	Yes ☐	No ☐
Spinal operation:	Yes ☐	No ☐

Do you suffer from digestive problems?

Gastric reflux:	Yes ☐	No ☐
Stomach ulcer:	Yes ☐	No ☐

Do you suffer from liver related problems (cirrhosis, hepatitis, jaundice)? Yes ☐ No ☐

Specify: _____

Do you suffer from blood related problems ?

Anemia:	Yes ☐	No ☐
Abnormal bleeding:	Yes ☐	No ☐
Frequent bruises :	Yes ☐	No ☐
Hemophilia:	Yes ☐	No ☐
Leukemia:	Yes ☐	No ☐
Thrombophlebitis:	Yes ☐	No ☐

In the past, have you ever received a blood transfusion?	Yes ☐	No ☐
Any reaction(s) during the transfusion ?	Yes ☐	No ☐

Specify: _____

PREOPERATIVE QUESTIONNAIRE

Do you suffer from?

Diabetes:	Yes ☐	No ☐	**Muscular disorder :**	Yes ☐	No ☐
Glaucoma:	Yes ☐	No ☐	**Motion sickness :**	Yes ☐	No ☐
Thyroid disorder:	Yes ☐	No ☐	**Urinary tract infection :**	Yes ☐	No ☐
Kidney disease:	Yes ☐	No ☐	**Genital infection (herpes,etc.) :**	Yes ☐	No ☐
Adrenal gland disease:	Yes ☐	No ☐	**HIV positive :**	Yes ☐	No ☐
Pituitary disorder:	Yes ☐	No ☐	**Hepatitis :**	Yes ☐	No ☐
Rheumatoid arthritis:	Yes ☐	No ☐	Hepatitis : A ☐ B ☐ C ☐		

Other: _____

More questions related to your health condition:

Do your ankles swell ? Yes ☐ No ☐

Under nice weather condition, how long can you walk ? _____

When walking, do you have cramps in your legs ? Yes ☐ No ☐

If necessary, how many stairs would you be able to climb ? _____

Are you treated in another hospital ? Yes ☐ No ☐

Specify: _____

Are you known by the CLSC ? (Quebec) Yes ☐ No ☐

Which one ? _____

Patient's signature: _____ **Date:** _____

: RESERVED SECTION

Checked by the nurse : _____ **Date:** _____