Halton Healthcare
GEORGETOWN • MILTON • OAKVILLE

PRE-OP SURGICAL QUESTIONNAIRE

GENERAL INFORMATION

Your name: ____
Last Name First Name

By what name should we call you:______________________What is your date of birth? ___________________

Your current height:_________________________________Your current weight: ________________________

Have you had previous operations? (Including C-sections). If YES, list below

Operations	Anaesthetic type, (if known)	Hospital	Anaesthetic Problems?
	❐ General ❐ Local ❐ Spinal/epidural		
	❐ General ❐ Local ❐ Spinal/epidural		
	❐ General ❐ Local ❐ Spinal/epidural		
	❐ General ❐ Local ❐ Spinal/epidural		
	❐ General ❐ Local ❐ Spinal/epidural		

ALLERGIES

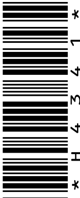
Do you have an allergy to Latex? ❐ Yes ❐ No ❐ Unknown

Do you have allergies and/or intolerances, adverse reactions? (i.e. medication, tape, food, etc.) List below:

Allergy	Reaction

ANAESTHETIC HISTORY

Have you or any blood relatives in your family ever had a bad reaction to anaesthetic?	❐ Yes ❐ No
Is there a family history of Malignant Hyperthermia (high fever) during anaesthetic?	❐ Yes ❐ No
Have you ever been told of difficulty with placement of breathing tube during anaesthetic?	❐ Yes ❐ No
Do you have pain/stiffness in your neck/jaw (TMJ)?	❐ Yes ❐ No
Do you have pain/stiffness in your lower back?	❐ Yes ❐ No
Do you have any loose teeth, capped teeth, braces, retainers, or dentures? (please circle appropriate response)	❐ Yes ❐ No
Do you have difficulty opening your mouth fully?	❐ Yes ❐ No
Have you had confusion after surgery?	❐ Yes ❐ No
Are you, or could you be pregnant?	❐ Yes ❐ No



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HOME MEDICATIONS:
Please list any medications, supplements or herbal preparations that you are currently taking at home.

		When do you take your medications?					
Medication Name	**Dose or Strength**	**A.M.**	**Noon**	**P.M.**	**Bedtime**	**Other**	**As Needed**

Pharmacy Name and Phone #____

ADDITIONAL QUESTIONS

Are you taking pain killers regularly?	❒ Yes ❒ No
Do you smoke or vape any of the following products: ❒ Cigarettes ❒ Cigars ❒ Marijuana Number per day:_______________ Number of years:_______________ Quit date:_____________________	❒ Yes ❒ No
Do you drink alcohol? If yes, how many drinks per week? ________________________________	❒ Yes ❒ No
Do you or are you currently taking recreational drugs? (eg. marijuana, cocaine, heroin, etc) If yes, when was the last time taken?______________________________	❒ Yes ❒ No

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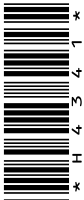
HEART HEALTH

Do you have or have you had any problems with your heart?	❒ Yes ❒ No
Please indicate if you have any of the follow conditions. Circle all that apply to you. Heart attack (MI) / Heart murmur / Chest pain (angina) Blockages / Stent (Angioplasty) / Valve problems Peripheral vascular disease / Heart surgery / Irregular heart beat Heart failure (CHF) / Pacemaker or implanted defibrillator	
Do you have high blood pressure?	❒ Yes ❒ No
Have you had any recent heart tests in the last 2 years? (Not ECG) (e.g. stress test, holter monitor, echocardiogram)	❒ Yes ❒ No
Do you have difficulty doing either of the following: Walking one (1) block Climbing one flight of stairs	 ❒ Yes ❒ No ❒ Yes ❒ No
Do you feel short of breath when lying flat?	❒ Yes ❒ No
Have you ever had blackouts or fainting spells?	❒ Yes ❒ No
Have you ever been told you have an aneurysm?	❒ Yes ❒ No
Have you seen a Cardiologist in the past 2 years? Cardiologist's name: ___________________________ Phone Number_____________: ___________________	❒ Yes ❒ No

BLOOD HEALTH

Do you have or have you had any problems with your blood or circulation?	❒ Yes ❒ No
Please indicate if you have any of the follow conditions. Circle all that apply to you. Sickle cell trait / Sickle cell anemia / Anemia (low blood count) A blood clot (lungs, legs) / Stroke / Abnormal bleeding HIV / Aids / Hepatitis	
Have you received blood or blood products in the last 3 months? Have you ever had a blood transfusion?	❒ Yes ❒ No ❒ Yes ❒ No
Do you have any personal or religious reasons to decline blood or blood products?	❒ Yes ❒ No
If female, how many pregnancies have you experienced?	Number:______
Have you seen a Specialist in the past 2 years? Specialist name: ______________________________ Phone Number : ______________________________	❒ Yes ❒ No



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ENDOCRINE AND METABOLIC HEALTH

Do you have diabetes?	❒ Yes ❒ No
If yes, how do you manage it? ❒ Insulin ❒ Diabetic Pills ❒ Diet only	
Do you have thyroid problems?	❒ Yes ❒ No

RESPIRATORY HEALTH

Do you or have you had any breathing problems?	❒ Yes ❒ No
Please indicate if you have any of the follow conditions. Circle all that apply to you. Asthma Chronic obstructive pulmonary disease (COPD) Tuberculosis (TB) Tracheostomy	
Do you use oxygen at home to help you breathe?	❒ Yes ❒ No
Have you seen a Respirologist in the past 2 years? Respirologist's Name: ____________________ Phone Number__________:____________	❒ Yes ❒ No
Do you have sleep apnea? (diagnosed by a sleep study)	❒ Yes ❒ No
Was a CPAP machine recommended for you? If yes, do you use your CPAP machine? ____________	❒ Yes ❒ No
If you answered no or unknown to having sleep apnea:	❒ Yes ❒ No
Do you snore loudly?	❒ Yes ❒ No
Do you often feel tired, fatigued, or sleepy during the daytime?	❒ Yes ❒ No
Has anyone observed you stop breathing or choking/gasping during your sleep?	
Do you have or are being treated for high blood pressure?	❒ Yes ❒ N
For Clinic Use only: Gender = male	❒ Yes ❒ No
Age greater than 50 years	❒ Yes ❒ No
	STOPBANG Score:

STOMACH AND INTESTINAL HEALTH

Do you have or have you had any problems with your stomach or intestines?	❒ Yes ❒ No
Please indicate if you have any of the follow conditions. Circle all that apply to you. Feeding tube Heartburn or Reflux Hiatus hernia Inflammatory Bowel disease Liver disease (hepatitis, jaundice)	
Do you have difficulty eating or swallowing?	❒ Yes ❒ No
Do you have any nausea, vomiting, choking?	❒ Yes ❒ No
Do you currently have an ostomy?	❒ Yes ❒ No

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KIDNEY AND BLADDER HEALTH

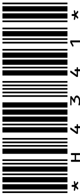
Do you have kidney disease?	❒ Yes ❒ No
Are you on dialysis? If yes, please circle all that apply: Hemodialysis Peritoneal dialysis	❒ Yes ❒ No
Have you seen a Nephrologist in the past 2 years? Nephrologist's name: ____________________ Phone:____________________	❒ Yes ❒ No

NERVE, MUSCLE AND BONE HEALTH

Do you have or have you had any problems with your nerves, muscles or bones?	❒ Yes ❒ No
Please indicate if you have any of the follow conditions. Circle all that apply to you. Multiple sclerosis Parkinson's disease ALS Stroke or stroke symptoms Brain aneurysm Fibromyalgia Spinal cord problems (stenosis, scoliosis) Seizure disorder (epilepsy) Dementia Migraines Neuropathy Alzheimer's disease Fainting spells (vertigo) in past 2 years Creutzfeldt-Jakob disease (CJD)	
Please indicate if you have any of the follow conditions. Circle all that apply to you. Osteoarthitis Anklosing spondylitis Rheumatoid arthritis	
Have you seen a Neurologist or Rheumatologist in the past 2 years? Specialist's name:____________________ Phone: ____________________	❒ Yes ❒ No

OTHER

Have you had overnight hospitalization within the past year? If yes, please state why:____________________	❒ Yes ❒ No
Do you have a history of mental health issues? If yes, please state:____________________	❒ Yes ❒ No
Do you use any ambulatory aids? If yes, please circle all that apply: Wheelchair Walker Cane Crutches	❒ Yes ❒ No
Have you ever had cancer? If yes, please circle all that apply: Radiation Chemotherapy Other:__________	❒ Yes ❒ No
Do you have any body piercings?	❒ Yes ❒ No



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PRE-OP SURGICAL QUESTIONNAIRE

Are there any additional health issues/concerns we should be aware of before your surgery? Please list:	❐ Yes ❐ No

I confirm the information provided in this document is accurate to the best of my recollection and abilities.

Signature of Patient ______________________ **Date** ______________________

Signature of Substitute Decision Maker (if required) ______________________ **Substitute Decision Maker Name (Print)** ______________________

Relationship to Patient ______________________

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Name: ______________________________

CATARACT SURGERY

Oakville Trafalgar Memorial Hospital

For Clinic Use Only

Date of Surgery: ______________________________

Time to Arrive: ______________________________

The Pre-Admission Clinic will contact you within a week before your procedure to confirm the time of surgery

Reminder: Bring your envelope with you to all appointments.

PATIENT PREPARATION

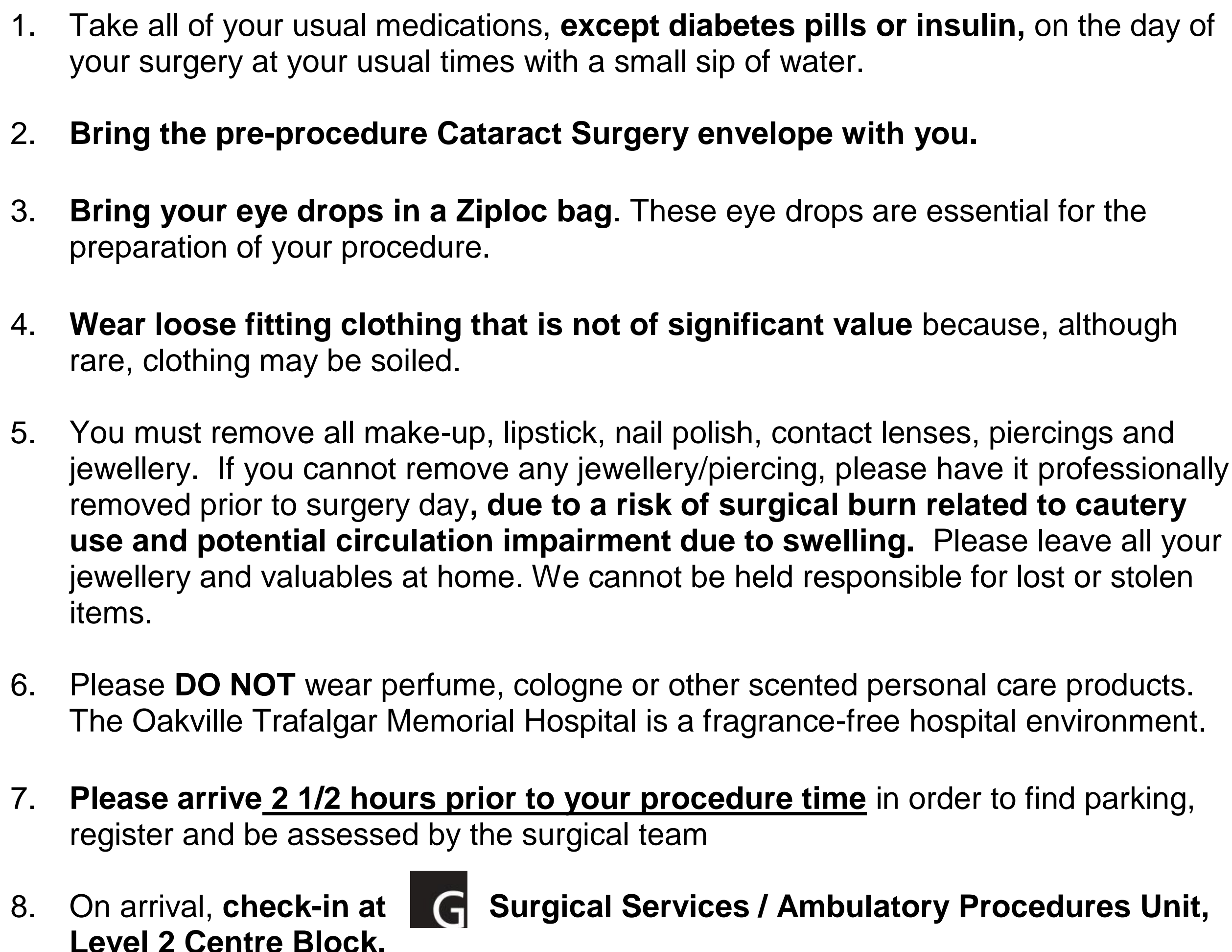
1. **Nothing to eat or drink** after midnight. You may have clear fluids such as black tea or coffee, water, apple juice, ginger ale up to 6 hours before your surgery time. No orange juice, milk, gum or candy.

2. **Arrange for a family member/friend to accompany you the day of surgery.** Your loved one will remain by your side for the majority of your surgical journey.

3. **DO NOT** smoke the day before and for 2-3 days after your surgery. The Oakville Trafalgar Memorial Hospital is a smoke-free facility.

Please see page 2 for “Patient Instructions – Day of Procedure”

PATIENT INSTRUCTIONS - DAY OF PROCEDURE



1. Take all of your usual medications, **except diabetes pills or insulin,** on the day of your surgery at your usual times with a small sip of water.

2. **Bring the pre-procedure Cataract Surgery envelope with you.**

3. **Bring your eye drops in a Ziploc bag**. These eye drops are essential for the preparation of your procedure.

4. **Wear loose fitting clothing that is not of significant value** because, although rare, clothing may be soiled.

5. You must remove all make-up, lipstick, nail polish, contact lenses, piercings and jewellery. If you cannot remove any jewellery/piercing, please have it professionally removed prior to surgery day**, due to a risk of surgical burn related to cautery use and potential circulation impairment due to swelling.** Please leave all your jewellery and valuables at home. We cannot be held responsible for lost or stolen items.

6. Please **DO NOT** wear perfume, cologne or other scented personal care products. The Oakville Trafalgar Memorial Hospital is a fragrance-free hospital environment.

7. **Please arrive 2 1/2 hours prior to your procedure time** in order to find parking, register and be assessed by the surgical team

8. On arrival, **check-in at G Surgical Services / Ambulatory Procedures Unit, Level 2 Centre Block.**

If you have any questions or concerns, contact the ***Pre-Admission Clinic at 905-338-4497***

FREQUENTLY ASKED QUESTIONS

What is Day Surgery/Surgical Day Care?
Day Surgery means that you will be having a surgical procedure and be discharged home on the same day. Because of improvements in medicine, anaesthesia and technology, many surgical procedures do not require you to stay in the hospital overnight.

What if my health changes before surgery?
If you do not feel well or there is a change in your health before your surgery, please call your surgeon's office as soon as possible. For example, if you have a cold or other illness, discuss this with your surgeon.

What should I expect when I arrive?
You will first register at Surgical Day Care with the unit clerk.

You will be seen by a nurse who will ask you a few questions and take your pulse, temperature and blood pressure. The nurse will also start an intravenous line in your hand and instill a total of six drops in the operative eye.

You will then be taken to the Operating Room in a recliner. The anaesthesiologist, operating room nurse and surgeon may ask you a few questions at this time. Once you enter the Operating Room, staff will put a blood pressure cuff on your arm, an oxygen monitor on your finger, a heart monitor on your chest and a mask on your face to deliver oxygen. At this time, you will be involved in the briefing portion of the Surgical Safety Checklist. Then, you will be given an anaesthetic and the procedure will begin.

Important:
The Operating Room may be needed for life threatening emergencies. Although this does not occur often, we do not know in advance when these emergencies are going to occur. If an emergency does happen, the time or date of your surgery may be changed. You will be notified of any changes as soon as possible.

For Your Safety:

Even though you are awake soon after your day surgery, you may feel drowsy for 24 to 48 hours after the surgery.

It is important that you **DO NOT:**

- drive a car or operate hazardous machinery for 24 hours
- drink alcohol for 24 hours
- take any medication unless prescribed by your physician
- make any important or legally binding decisions until you have recovered

Discharge Instructions

In order to be discharged, you must have a responsible adult relative or friend take you home after your surgery. ***It is important that this adult be available to stay with you for at least 12 to 24 hours after your surgery.***

IMPORTANT!
You must arrange for someone to escort you home from the hospital. If you do not have a responsible adult to take you home, your surgery will be cancelled. You and your friend or relative must go home by car or taxi, **NOT** by public transit.

Please make plans to ***GO STRAIGHT HOME*** and rest for the day following your surgery. Arrange to have a responsible adult stay with you to ensure that you are okay.

Other Appointments

Date:____

Time:____

Location:____

Date:____

Time:____

Location:____

Date:____

Time:____

Location:____

NOTES:

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CONFIDENTIAL ADMISSION FORM

Accommodation requests will be based on availability at the time of admission.

Have you received any treatment in this hospital before? ❐ Yes ❐ No	Has your name changed since your previous visit? ❐ Yes ❐ No If "Yes", please indicate previous name: ____________
Family Physician	Attending Physician
Allergies	

Patient Information			**Partner or Next-of-Kin Information**		
Patient Surname	Given Name(s)		Surname	Given Name(s)	
Date of Birth	Sex	Marital Status ❐ Single ❐ Separated ❐ Married ❐ Divorced ❐ Widowed ❐ Common-Law	Address		
Address			City	Province	Postal Code
City	Province	Postal Code	Home Phone	Cell Phone	
Home Phone	Cell Phone		Work Phone		
Work Phone			Relation to Patient		
Employer Name and Address					
Preferred Language			Religion		
Do you have an Advance Directive? ❐ Yes ❐ No	Do you have a Living Will? ❐ Yes ❐ No	Do you have a Substitute Decision Maker ❐ Yes ❐ No If ":Yes", Name and Phone Number:			

Hospital and Medical Insurances

Health Card Number (10 digits)	Version Letters on Health Card	Surname and Initials as Shown on the Health Card

Accommodation	**Coverage**
❐ Ward	❐ I do not have insurance coverage. Please bill me directly.
❐ Semi Private	❐ I have some coverage. Please bill my insurance company and bill me for any remaining balances
❐ Private	❐ I have full coverage. Please bill my insurance company directly

All self-pay accounts should be paid upon discharge.

Extended Healthcare Benefit Insurance Information and Coverage

Name of Insurance Company		
Surname and Given Name of Certificate Holder (as registered with insurance company)		Patient Relation to Insurance Holder ❐ Holder ❐ Child ❐ Spouse
Group Policy Number	Identification or Certificate Number	Certificate Holder's Date of Birth
Employer Name	Employer's Address	

I understand it is my responsibility to verify my insurance coverage.

Signature of Patient: ____________ Signature of Registration Clerk: ____________ Date: ____________