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		

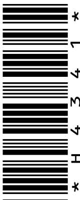
ALLERGIES

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:

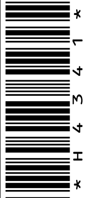
Please list any medications, supplements or herbal preparations that you are currently taking at home.

		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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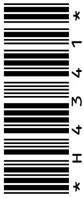
PRE-OP SURGICAL QUESTIONNAIRE

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	❒ Yes ❒ No
Climbing one flight of stairs	❒ 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?	❒ Yes ❒ No
Have you ever had a blood transfusion?	❒ 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? ____________ ***If you answered no or unknown to having sleep apnea:*** Do you snore loudly? Do you often feel tired, fatigued, or sleepy during the daytime? Has anyone observed you stop breathing or choking/gasping during your sleep? Do you have or are being treated for high blood pressure?	❐ Yes ❐ No ❐ Yes ❐ No ❐ Yes ❐ No ❐ Yes ❐ No ❐ 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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PRE-OP SURGICAL QUESTIONNAIRE

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 ____________________

If you have your own medication list with you, you do not have to fill out this form.

Patient / Family-Recorded Home Medication List

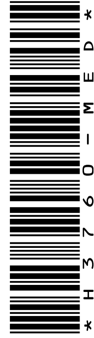
Date Recorded: ____________________________________

Pharmacy name and phone number:

Allergies (Describe Reaction): ❐ **No Known Allergies**

Currently Taking Medications / Supplements at Home?
❐ No ❐ Unknown

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



COMPLETED BY: ❐ Patient ❐ Family ❐ Health Care Professional

Help Us Keep You Safe – Know Your Medications!

See over →

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Patient / Family-Recorded Home Medication List

Why create a Home Medication List?

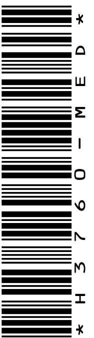
Your Home Medication List is a tool to help you and your family keep track of all the medications you are taking. It is important to write down everything, including vitamins and supplements, so your healthcare team can provide you with the best possible care. Certain medications might interact with another medication on your list; so, it is important that your Home Medication List be correct and up-to-date.

Instructions for Patient or Family:

1. List **ALL** prescription medications, non-prescription medications, vitamins, herbal and naturopathic products, and/or drug trials.
2. Write the dosage of each medication.
3. For each medication write the number of pills you take at the listed times. See examples.
   - If your medication time is not listed, write the time you take it in the "Other" column
4. If the name of medication is unknown, describe pill under "Medication Name", and indicate why you are taking it.
5. Your list will be photocopied and put on your hospital file.
6. Always keep a copy of your *Home Medication List* with you.
7. If you stop taking something or start a new medication, be sure to update this list.
8. If you have any questions about your medication or filling out this form, contact your doctor or pharmacist.

EXAMPLES:

Medication Name	Dose or Strength	AM	Noon	PM	Bedtime	Other	As Needed
Metformin	500mg	2		2			
Tylenol Arthritis	650mg					1 at 10:30 am	
Natural Tears	1 drop in left eye						√
Hydrocortisone Cream	0.1% To arm				1		
Vitamin D	1000 units	1					



Help Us Keep You Safe – Know Your Medications!

CHLORHEXIDINE – CHD SHOWER INSTRUCTIONS BEFORE SURGERY

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Department of Surgery

Purchase one 4oz (115mL) bottle Chlorhexidine gluconate 4% (CHD) from your local pharmacy

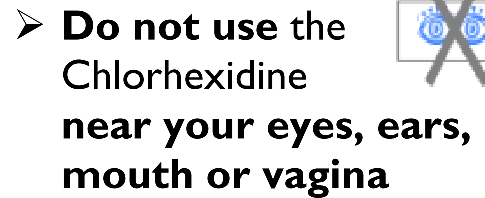
DIRECTIONS:

Take **TWO** showers, **one** the **night before surgery** and **another** the **morning of surgery**

1. Remove all jewelry and body piercings.
2. Wash your hair and body using your normal soap and shampoo. Rinse. Step away from the water.
3. Wet a clean washcloth and apply **CHD** solution to the wet washcloth. Use half of the **CHD** for the first shower and half for the next one.
4. Wash your entire body **from the neck down** using the wet, soapy washcloth. Clean your belly button thoroughly with Q-tips and **CHD**, (wash your outer genital and anal areas last). Leave the solution on the skin for **3 minutes**, then rinse the cleaner thoroughly from your body.
5. Use a clean towel to pat your skin dry.
6. Dress in fresh clean sleepwear/clothes. Sleep in clean sheets the night before your surgery.

If you have any questions or concerns, contact your surgeon

DO NOT !



- **Do not use** the Chlorhexidine **near your eyes, ears, mouth or vagina**
- **Do not use** if you are allergic to Chlorhexidine; consult your surgeon
- **Do not** apply body moisturizing lotion or powder after your shower
- **Do not** shave, clip, or wax below your neck for 7 days before surgery

IMPORTANT!

- If you experience any **signs of allergy,** for example, a rash, breathing difficulties, palpitations, or swelling of the lips, tongue and throat, or if you feel unwell in any way, **STOP** use and please seek medical advice immediately, visit your Emergency Department, family doctor, or call Telehealth Ontario (1-866-797-0000) or 911

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Name: ______________________________________

DAY SURGERY
at Oakville Trafalgar Memorial Hospital

For Clinic Use Only

Date of Surgery: ______________________________________

Time to Arrive: ______________________________________

Instructions for the night before your surgery:

1. Please **DO NOT** have anything to eat or drink after midnight ____________________________.

   Remember: no gum, candy or water during fasting time. If indicated, you may have clear fluids (e.g., black tea or coffee, water, apple juice, ginger ale) until 6 hours before your surgery time: ______________________________. Please **DO NOT** drink *orange juice or milk* during this time.

2. Bring your completed Home Medication list . If requested, also bring your daily medications.
3. These are the medications to take on the morning of your surgery:

   ____

   ____

   ____

4. Please **DO NOT** smoke the day before and for 2-3 days after your surgery. OTMH is a smoke-free facility.
5. You must remove all make-up, lipstick, nail polish, contact lenses, piercings and jewellery (see note on Page 3 “What Should I Wear”).
6. Leave all your jewellery and valuables at home. We cannot be held responsible for lost or stolen items.
7. Please **DO NOT** wear perfume, cologne or other scented personal care products. The Oakville Trafalgar Memorial Hospital is a fragrance-free hospital environment.
8. Remember to bring your eyeglass case and denture cups, if you use these items.

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

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 is a Pre-Admission Appointment?

The pre-admission appointment is important to prepare you for surgery. It includes speaking with a Registered Nurse who will arrange any blood tests, x-rays or other tests that may be required. This appointment will take approximately 60 minutes. The appointment may be longer if you are required to see the anaesthetist.

On the day of your pre-admission appointment, you may eat and drink as usual.

Please bring the following with you to your Pre-Admission Clinic visit:

Item	Details
Your Pre-Admission Clinic Package	Given to you by the surgeon.
Pre-Operative Surgical Questionnaire	**Completed by you** BEFORE your pre-admission visit.
Confidential Admission form	**Completed by you** BEFORE your pre-admission visit.
Medication List from your pharmacy or your medications in their original containers	
Your Ontario Health card	

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 do on the day of surgery?

On the day of your surgery, you should report to the Surgical Services/Ambulatory Procedures Unit located on the 2nd floor. Follow the signs provided throughout the hospital.

Please arrive at the time that you have been instructed during your Pre-Admission visit. Be aware that, if you are late, your surgery may be delayed or re-scheduled. Occasionally, the time of your surgery may change. The Pre-Admission Clinic will notify you of any time changes one business day before your surgery.

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.

What should I wear?
Please wear loose fitting clothing and flat shoes. We will provide you with a hospital gown. Do not wear make-up, nail polish, contact lenses or any jewellery, including all piercings. If you cannot remove any jewellery/piercing, please have it professionally removed prior to your surgery day, due ***to a risk of surgical burn related to cautery use and potential circulation impairment due to swelling.*** You can wear hearing aids, dentures and glasses, but you will be asked to remove them before surgery. Please bring a hearing aid case, a denture cup and a case for your glasses, if needed.

On the Day of your Surgery
We will ask you to change into a hospital gown. You will be seen by a nurse who will ask you a few questions and will take your pulse, temperature and blood pressure. The nurse will start an intravenous line in your hand.

The Patient Waiting Area
You will wait in the patient waiting area. From this area, we will take you to the Operating Room.

Operating Room
We will help you onto the operating table. We 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.

Post Anaesthetic Care Unit (PACU)
You may be taken to the Post-Anaesthetic Care Unit (sometimes referred to as the Recovery Room) after your surgery. Whether or not you are taken to the PACU depends on the type of anaesthetic you had. The PACU is a large room and there may be several other patients in the room with you. During your stay in the PACU, you will probably hear the constant beep and whirl of the many machines that are monitoring patients. You may also see and hear a number of nurses and physicians going about their business.

The PACU nurses will measure your pulse, breathing and blood pressure frequently. You will wake up in the PACU. You may have an oxygen mask over your mouth and nose. Your stay in the PACU will be between half (1/2) an hour and two (2) hours, depending on the type of surgery you have had.

After PACU, you will return to Surgical Day Care. When you have recovered from the anaesthetic, you will be offered a drink of juice or ginger ale.

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 at your discharge time.*** They must also stay with you for at least 12 to 24 hours after your surgery.

Before you leave, a nurse will go over your instructions on how to take care of yourself at home.

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, <u>**NOT**</u> by public transit.

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.

<u>It is important</u> 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

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: ____________________