Print Clear Form

Providence HEALTH CARE

DT PROCEDURE ROOM PRE-OP HISTORY PATIENT QUESTIONNAIRE (PHC)

* 3 0 0 7 *

Medical Questionnaire

Dear Patient: Please complete this health history questionnaire to the best of your ability.
Check all answers that apply. You can write additional detail in the "specify" or "comments" section.
Give the completed form to the team at your surgeon's office.

Patient name: _____

Date of birth (dd/mmm/yyyy) _____ **Gender:** ☐ Male ☐ Female ☐ Other: _____

Address: _____

Preferred phone number: _____ **Email:** _____

Height: _____ feet _____ inches ***or*** _____ cm **Weight:** _____ lb ***or*** _____ kg

Preferred language: _____ ☐ Interpreter required

Family Doctor: _____

Do you have any allergies:

☐ Medication (s*pecify*): _____
☐ Food (s*pecify):* _____
☐ Latex ☐ Tape/bandages ☐ Iodine ☐ IV contrast
☐ Other allergies *(specify)*: _____

Do you:

☐ Smoke tobacco of any kind? (e.g. cigarettes, cigars, pipes, vapes) (s*pecify):* _____
How many per day: _____ *For how many years:* _____
☐ Drink alcohol *How many drinks per week:* _____
☐ Use non-prescribed substances? (s*pecify):* _____ *How often:* _____

Do you have any heart problems? *Specify below*

☐ High blood pressure ☐ Chest pain/angina → *Last episode:* _____
☐ Irregular heart beat ☐ Heart surgery ☐ Pacemaker or implantable defibrillator
☐ An artificial heart valve ☐ Bleeding/clotting disorder ☐ Hemophilia
☐ Other heart conditions: (s*pecify):* _____

Do you take blood thinners such as:

☐ warfarin (Coumadin) ☐ clopidogrel (PLAVIX)
☐ Other blood thinners (s*pecify):* _____
☐ Do you take Aspirin (ASA) regularly, w*hy?* _____

Do you have any breathing problems? *Specify below*

☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (emphysema or chronic bronchitis)
☐ Home oxygen ☐ Inhalers (puffers), how often? _____
☐ Sleep apnea ☐ Use a CPAP/ BIPAP machine
☐ Active tuberculosis ☐ A problem lying down for 30 minutes or more because of difficulty breathing?
☐ Other breathing problems (s*pecify):* _____

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Medical Questionnaire

Do you have:

☐ Diabetes → ☐ on insulin ☐ on diabetic pills ☐ diet controlled

☐ Kidney disease → ☐ on dialysis

☐ Thyroid disease

☐ Epilepsy/seizures/convulsions - *Last episodes:* _____

☐ Dizziness ☐ History of stroke or stroke like symptoms

☐ Fainting spells ☐ A disease that affects your muscles and nerves

☐ Memory problems or confusion ☐ History of extreme confusion after an operation

OTHER IMORTANT MEDICAL INFORMATION	**Yes**	**No**	**Comments**
Have you had previous surgery? *Last surgery date:* _____	☐	☐	
Have you had serious problems following an anesthetic (e.g. malignant hyperthermia?)	☐	☐	
Do you have family (blood relatives) who have had serious problems following an anesthetic?	☐	☐	
Have you had problems or reaction to local freezing (anesthetic)?	☐	☐	
Have you have had an infection requiring isolation in the hospital?	☐	☐	
Are you prone to having anxiety attacks? Do you take medication for it?	☐	☐	
Do you have a chronic pain disorder?	☐	☐	
Do you have problems with your balance?	☐	☐	
Have you had a fall in the past 3 months?	☐	☐	
Do you use a wheelchair, cane, scooter or other walking aid?	☐	☐	
Do you wear a hearing aid(s)?	☐	☐	

Do you have any other illness, limitations or concerns we should know about?

List all of the medications that you take: (including herbal, vitamins, and non-prescription drugs)

Who is the person responsible for picking you up and driving you home after your surgery?

Name: _____ Phone number: _____

Patient Questionnaire completed by:

☐ Patient ☐ Other, specify relationship to the patient: _____

Print name	Signature	Date (dd/mmm/yyyy)