



Please complete this form & bring it with you on the day of your Pre-Surgical appointment or surgery.

GBHS Pre-Surgical Screening Questionnaire

(To be filled out by the patient. Please complete both sides of this form)

Name: Last		First:	Middle:
D.O.B.: (yyyy/mm/dd)		Health Card # Version Code: (2 letters at the end of number)	Height: Weight:
Family Physician:			
Information given by: <input type="checkbox"/> Patient <input type="checkbox"/> Other		Do you speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred language:
Social Habits:			
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many per day?
Do you drink alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No		How much?	How often?
Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No		Type:	How often?
Anaesthesia / Transfusion History:			
Have you ever had general anaesthetic? <input type="checkbox"/> Yes <input type="checkbox"/> No		When?	
Did you have any type of reaction to the anaesthetic? <input type="checkbox"/> Yes <input type="checkbox"/> No		What happened to you?	
Do you have loose, capped or bridged teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No		Partial or full dentures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Body piercing(s)? Where? <input type="checkbox"/> Yes <input type="checkbox"/> No
Currently taking Aspirin or drugs that contain Aspirin? <input type="checkbox"/> Yes <input type="checkbox"/> No		What type?	
Do you take blood thinners <input type="checkbox"/> Yes <input type="checkbox"/> No		What type?	What for?
Do you take steroids by mouth or inhalations? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have a family history of malignant hyperthermia? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Could you be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many times have you been pregnant? _____	
Have you been pregnant in the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you had a MRSA or VRE infection? ("Superbug") <input type="checkbox"/> Yes <input type="checkbox"/> No		When?	When was the last time tested?
Do you have an allergy to latex? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you been admitted overnight in any hospital in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever had a blood transfusion or blood products? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes	Date: Hospital:
Did you have any type of reaction to the blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Airway Management:			
Are you able to open your mouth wide? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you able to extend your neck without difficulty <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever been told you have a difficult airway? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have sleep apnea? <input type="checkbox"/> Yes <input type="checkbox"/> No		If 'Yes', do you use a CPAP machine to help you breathe when you sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No	

GBHS Pre-Surgical Screening Questionnaire (Cont'd)

List any major illnesses or operations that you have had in the past.

List any allergies you have:

Allergy	Reaction

List all the medications that you are currently taking:

Drug	Dose	How often?	Reason

Do you have any of the following disorders?

<input type="checkbox"/> Irregular heart	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Previous heart attack	<input type="checkbox"/> Angina/chest pain
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Blackouts/fainting spells
<input type="checkbox"/> Migraine headache	<input type="checkbox"/> Epilepsy/Seizure disorder	<input type="checkbox"/> Bleeding problems
<input type="checkbox"/> Blood clots/Phlebitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Anaemia	<input type="checkbox"/> Hiatus hernia/reflux disorder	<input type="checkbox"/> Asthma/Bronchitis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Emphysema or COPD
<input type="checkbox"/> Chronic or acute pain	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Frequent cough
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Other: _____	

Release of Responsibility

I hereby assume all responsibility for any items of clothing, hearing aids, watches, teeth, toilet articles, jewelry, money or any other type of personal possessions whatsoever, retained or brought in for the use of _____ (Self or Name of Patient) while a patient at GBHS and I release the hospital corporation and its employees from any liability which may result from the loss or damage to any of the said articles by any means whatsoever.

Signature of Patient / Parent / Legal Guardian _____ Relationship Items sent to Business Office: Yes No

Date: _____