GREY BRUCE Health SERVICES

Patients to complete both sides of this form & bring to Pre-Surgical appointment or surgery.

GBHS Pre-Surgical Screening Questionnaire

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: ☐ Patient ☐ Other	**Do you speak English?** ☐ Yes ☐ No	**Preferred language:**

Social Habits:		
Do you smoke? ☐ Yes ☐ No	Have you ever smoked? ☐ Yes ☐ No	How many per day?
Do you drink alcohol ☐ Yes ☐ No	How much?	How often?
Do you use recreational drugs? ☐ Yes ☐ No	Type:	How often?

Anaesthesia / Transfusion History:		
Have you ever had general anaesthetic? ☐ Yes ☐ No	When?	
Did you have any type of reaction to the anaesthetic? ☐ Yes ☐ No	What happened to you?	
Do you have loose, capped or bridged teeth? ☐ Yes ☐ No	Partial or full dentures? ☐ Yes ☐ No	Body piercing(s)? Where? ☐ Yes ☐ No
Currently taking Aspirin or drugs that contain Aspirin? ☐ Yes ☐ No	What type?	
Do you take blood thinners ☐ Yes ☐ No	What type?	What for?
Do you take steroids by mouth or inhalations? ☐ Yes ☐ No		
Do you have a family history of malignant hyperthermia? ☐ Yes ☐ No		
Could you be pregnant? ☐ Yes ☐ No Have you been pregnant in the last 3 months? ☐ Yes ☐ No	How many times have you been pregnant? _____	
Have you had a MRSA or VRE infection? ("superbug") ☐ Yes ☐ No	When?	When was the last time tested?
Do you have an allergy to latex? ☐ Yes ☐ No		
Have you been admitted overnight in any hospital in the last 12 months? ☐ Yes ☐ No		
Have you ever had a blood transfusion or blood products? ☐ Yes ☐ No	**If Yes** Date: Hospital:	
Did you have any type of reaction to the blood transfusion? ☐ Yes ☐ No		
Have you had a heart attack in the last year ☐ Yes ☐ No	**If Yes** did you receive: ☐ a stent ☐ heart surgery ☐ medical therapy (medication)	

Airway Management:	
Are you able to open your mouth wide? ☐ Yes ☐ No	
Are you able to extend your neck without difficulty ☐ Yes ☐ No	
Have you ever been told you have a difficult airway? ☐ Yes ☐ No	
Do you have sleep apnea? ☐ Yes ☐ No	If 'Yes", do you use a CPAP machine to help you breathe when you sleep? ☐ Yes ☐ No

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?

☐ Irregular heart	☐ Heart murmur	☐ Pacemaker
☐ Heart disease	☐ Previous heart attack	☐ Angina / chest pain
☐ High blood pressure	☐ Stroke	☐ Blackouts / fainting spells
☐ Migraine headache	☐ Epilepsy / Seizure disorder	☐ Bleeding problems
☐ Blood clots / Phlebitis	☐ Diabetes	☐ Glaucoma
☐ Anemia	☐ Hiatus hernia / reflux disorder	☐ Asthma / Bronchitis
☐ Kidney disease	☐ Liver disease	☐ Emphysema or COPD
☐ Chronic or acute pain	☐ Rheumatoid Arthritis	☐ Frequent cough
☐ Shortness of breath	☐ 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.

_____ _____ Items sent to Business Office: ☐ Yes ☐ No

Signature of Patient / Parent / Legal Guardian Relationship

Date:_____