

PRE-OPERATIVE SURGICAL QUESTIONNAIRE

PATIENT INFORMATION

Last Name: _____ First Name: _____

Preferred Name (if applicable): _____ Birthdate (YYYY/MM/DD): _____

Current Height (cm): _____ Current Weight (kilograms): _____

Previous Surgeries (Including C-Sections):

Surgery/Procedure	Year	Hospital	Anesthetic Problems? If yes, please specify issue	
			<input type="checkbox"/> No	<input type="checkbox"/> Yes:
			<input type="checkbox"/> No	<input type="checkbox"/> Yes:
			<input type="checkbox"/> No	<input type="checkbox"/> Yes:
			<input type="checkbox"/> No	<input type="checkbox"/> Yes:
			<input type="checkbox"/> No	<input type="checkbox"/> Yes:
			<input type="checkbox"/> No	<input type="checkbox"/> Yes:

ALLERGIES

Do you have an allergy to Latex? Yes No

List all allergies and/or intolerances or adverse reactions (i.e. medication, adhesive/tape, food, etc.)

Allergy	Reaction

ANAESTHETIC HISTORY

Have you or any blood relatives in your family ever had a bad reaction to anaesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a family history of Malignant Hyperthermia (high fever) during anaesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been told of difficulty with placement of breathing tube during anaesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your jaw (TMJ) ever lock on you when you open your mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have pain/stiffness in your lower back?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have numbness/tingling down your arms when you move your neck?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any loose teeth or dentures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty opening your mouth fully?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had confusion after surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you, or could you be pregnant? (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No

H4341

PRE-OPERATIVE SURGICAL QUESTIONNAIRE

HEART HEALTH

Do you have, or have you ever had any problems with your heart or lungs? If yes, please check the appropriate condition(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Heart Attack (MI) <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Chest Pain (Angina) <input type="checkbox"/> Blockages <input type="checkbox"/> Stent <input type="checkbox"/> Valve Problems <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Heart Failure (CHF) <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Pacemaker or defibrillator <input type="checkbox"/> Other: _____	
Have you had any heart tests in the last 2 years? (Not ECG) (e.g. stress test, holter monitor, echocardiogram)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty doing either of the following: <input type="checkbox"/> Walking one block <input type="checkbox"/> Climbing one flight of stairs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel short of breath when lying flat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had blackouts or fainting spells?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been told you have an aneurysm?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you seen a Cardiologist in the past 2 years? Cardiologist's Name: _____ Phone Number: _____ Fax Number: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

ENDOCRINE AND METABOLIC HEALTH

Do you have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how do you manage it? <input type="checkbox"/> Insulin <input type="checkbox"/> Diabetic Pills <input type="checkbox"/> Diet only	
If yes, do you use an insulin pump?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have thyroid problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No

BLOOD HEALTH

Do you have, or have you ever had any problems with your blood or circulation? If yes, please check the appropriate condition(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Anemia (low blood count) <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hepatitis <input type="checkbox"/> A blood clot in your lung Year of diagnosis: _____ <input type="checkbox"/> A blood clot in your leg(s) Year of diagnosis: _____	
Have you received blood or blood products in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a blood transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any personal or religious reasons to decline blood or blood products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you seen a Hematologist in the past 2 years? Hematologist's Name: _____ Phone Number: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

H4341



PRE-OPERATIVE SURGICAL QUESTIONNAIRE

RESPIRATORY HEALTH

<p>Do you have, or have you ever had any breathing problems?</p> <p>If yes, please check the appropriate condition(s):</p> <p><input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Tuberculosis (TB)</p> <p><input type="checkbox"/> Tracheostomy <input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Do you use oxygen at home?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Have you seen a Respiriologist in the past 2 years?</p> <p>Respiriologist's Name: _____</p> <p>Phone Number: _____ Fax Number: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Do you have sleep apnea? (diagnosed by a sleep study)</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Was a CPAP machine recommended for you?</p> <p>If yes, do you use your CPAP machine?</p> <p>What is the pressure on the CPAP machine? _____ cm H2O</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>If you answered no, or if you are unsure if you have sleep apnea:</p> <p>Do you snore loudly?</p> <p>Do you often feel tired, fatigued, or sleepy during the daytime?</p> <p>Has anyone observed you stop breathing or choking/gasping during your sleep?</p> <p>Do you have or are being treated for high blood pressure?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

STOMACH AND INTESTINAL HEALTH

<p>Do you have, or have you had any problems with your stomach or intestines?</p> <p>If yes, please check the appropriate condition(s):</p> <p><input type="checkbox"/> Feeding Tube <input type="checkbox"/> Heartburn or Reflux <input type="checkbox"/> Hiatus Hernia</p> <p><input type="checkbox"/> Crohn's disease <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Do you have difficulty eating or swallowing?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Do you regularly have any problems with nausea, vomiting, or choking?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Do you currently have an ileostomy or colostomy?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

H4341

PRE-OPERATIVE SURGICAL QUESTIONNAIRE

KIDNEY AND BLADDER HEALTH

Do you have kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you on dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please indicate which type: <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal Dialysis	
Have you seen a Nephrologist in the past 2 years? Nephrologist's Name: _____ Phone Number: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

NERVE, MUSCLE, AND BONE HEALTH

Do you have, or have you ever had any problems with your nerves, muscles, or bones?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please check the appropriate condition(s):	
<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Stroke or Mini-stroke (TIA) <input type="checkbox"/> Brain Aneurysm <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Spinal Cord Problems (stenosis, etc.) <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Migraines <input type="checkbox"/> Neuropathy <input type="checkbox"/> Fainting Spells or Vertigo <input type="checkbox"/> Dementia <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Other: _____	
If you have rheumatoid arthritis, do you ever have numbness or tingling when you move your head up and down?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you seen a Neurologist or Rheumatologist in the past 2 years? Specialist's Name: _____ Phone Number: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

OTHER

Have you ever had cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of cancer: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Year of diagnosis: _____	
Any areas of spread? Location(s): _____	
If you have had cancer, did you receive any of the following? <input type="checkbox"/> Radiation <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Surgery Month & year of last chemotherapy or radiation session (if applicable): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of mental health issues? If yes, please specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

H4341



PRE-OPERATIVE SURGICAL QUESTIONNAIRE

Do you use any mobility aids? If yes, please indicate all that apply: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any body piercings that cannot be removed by you or a professional piercer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any additional health issues/concerns we should be aware of before your surgery? Please List:	<input type="checkbox"/> Yes <input type="checkbox"/> No

FUNCTIONAL AND SOCIAL SUPPORT

Do you have an adult who is staying with you for 24 hours after surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an adult who can accompany you home after surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Patient Signature: _____ Date: _____

Signature of Substitute Decision Maker (if required) _____

Relationship to Patient: _____

H4341



CHLORHEXIDINE – CHD SHOWER INSTRUCTIONS BEFORE SURGERY

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

DAY SURGERY

at Oakville Trafalgar Memorial Hospital

For Clinic Use Only

Date of Surgery: _____

Time to Arrive: _____

Please check in at  Surgical Services / Ambulatory Procedures Unit, Level 2 Centre Block

 **Reminder: Bring your package with you to all appointments.**

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 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 2 hours. The appointment may be longer if you are required to see the anaesthetist. If you are attending our Wednesday clinic for hip or knee replacement, you should plan to be here for at least 4 hours.

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 your 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/piercings, please have it/them professionally removed prior to your surgery, ***due to a risk of surgical burn related to cautery use and potential swelling affecting circulation.*** 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.

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 have 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 be taken over to your room on the surgical floor where the nurses will monitor your pulse, breathing and blood pressure. The nurses will also get you to do some deep breathing and move your feet and toes.

Visiting Hours

There are no specified visiting hours. However, in our hospitals, quiet time has been designated from the hours of 10:00 p.m. until 7:00 a.m. every day to promote a restful, healing environment for our patients. All Halton Healthcare staff and physicians will work collaboratively with the patient and family member/ partner in care to make adjustments or changes in the care plan to support family presence, bearing in mind the principles of health, safety, privacy, and confidentiality of all patients.

What services are available while I am in the hospital?

- Gift Shop
- Tim Hortons/Starbucks
- Pharmacy
- Bank Machine
- Food Court
- Television, telephone, internet, movies, and games are available for a fee of \$15.00 per day. This fee includes access to available free education and information services. If you want to purchase these services, activation can be done on the touchscreen device beside your bed. Touch the **ACTIVATE SERVICES** icon and follow the onscreen instructions. You can also dial extension **7789** from the bedside device to activate services by phone.

If you want to pre-order these services for your planned hospital stay, there is a toll-free number to call and activate services. The toll-free number is 1-866-223-3686.

Payment for these services is by VISA or MasterCard only.

What should I bring to the hospital on the day of surgery?

You should bring the following items in a small bag labelled with your name.

- Toiletries (e.g., toothbrush, toothpaste, comb, brush, soap, shampoo, shaving kit, etc.)
- Lip and skin moisturizer (the air in the hospital is dry).
- Slippers and housecoat that opens all the way down the front.
- Socks and comfortable shoes with rubber soles (e.g., running shoes).
- Hearing aids, dentures, eyeglasses.
- Any walking aids such as canes or walkers.

Other Suggestions:

- A telephone calling card if you want to make a long distance phone call.
- A small amount of cash to cover the cost of newspapers, coffee, etc.
- Something to read.

Do not bring:

- Valuables such as watches or jewellery.
- Many pieces of identification or credit cards.
- A cellular phone.
- Large pieces of electrical equipment.

PLEASE NOTE: Patients are advised **not** to bring money or valuables into the hospital. The hospital **does not** assume responsibility for patient money or valuables. Patients choosing to bring them into the hospital do so **at their own risk**. It is recognized that patients will have personal items such as clothing, medications and personal support aids with them (e.g., eyeglasses, contact lenses, dentures, hearing aids, mobility aids such as canes, walkers, prostheses or wheelchairs, etc.). However, the hospital **will not** assume responsibility for these items if they are damaged or go missing. **Please mark all items with your name.**



CONFIDENTIAL ADMISSION FORM

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

Have you received any treatment in this hospital before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your name changed since your previous visit? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a Substitute Decision Maker <input type="checkbox"/> Yes <input type="checkbox"/> 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	
<input type="checkbox"/> Ward	<input type="checkbox"/> I do not have insurance coverage. Please bill me directly.	
<input type="checkbox"/> Semi Private	<input type="checkbox"/> I have some coverage. Please bill my insurance company and bill me for any remaining balances	
<input type="checkbox"/> Private	<input type="checkbox"/> 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 <input type="checkbox"/> Holder <input type="checkbox"/> Child <input type="checkbox"/> 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: _____