ST JOSEPH'S HEALTH CENTRE TORONTO

PRE-OPERATIVE PATIENT SELF ASSESSMENT

To be completed by the **Patient** and returned to the Surgeon's office as soon as possible.

OFFICE USE ONLY:
Name: _____ LAST NAME _____ FIRST NAME
Male ☐ Female ☐
J #: _____
DOB: _____
Address: _____
_____
Telephone: _____
OHIP #: _____

If you are **GOING HOME THE SAME DAY AFTER YOUR SURGERY**, you **MUST** have a responsible adult to take you home or your surgery will be cancelled. It is also recommended that you have someone stay with you overnight.

Demographic Information				
Patient Name: (Last, First)			Date of Birth (DD-MM-YYYY):	
Phone:	Home:	Work/Cell:	Preferred time of day to contact you:	☐ 8:00 am –12:00 pm ☐ 12:00 pm – 4:00 pm
Preferred Language:	☐ English ☐ Other:		Can we leave you a message?	☐ Yes ☐ No
Family Doctor & Contact Number:		Family Doctor Address:		

Blood Transfusion			
Have you ever had a blood transfusion or blood replacement?	☐ Yes ☐ No	Blood Type? (If known):	

Do you have any allergies? (Including medications, foods or environment)			
ALLERGY	Reaction	ALLERGY	Reaction

Are you taking any medications? (List all prescribed and non-prescribed medications, including herbal remedies)	
MEDICATION (Dose and Frequency)	MEDICATION (Dose and Frequency)

Additional medication related information:		
For medication dosing, please record your **height** _____ AND **weight** _____		
Have you been taking medication for **pain** routinely in the last 3 months?	☐ Yes ☐ No	
Do you take **aspirin, blood thinners,** or **anti-coagulants** on a regular basis?	☐ Yes ☐ No	
Have you taken **oral steroids** in the last year? *(e.g. Prednisone, Cortisone)*	☐ Yes ☐ No	
Name & phone number of current pharmacy:		
Please list any substances or recreational drug use regularly (type and frequency):		
Do you drink Alcohol?	☐ Yes ☐ No	If "yes", how many drinks per day?

Please list all of the surgeries you have had:			
Surgery:	Date:	Surgery:	Date:

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Medical History (check all that apply):	
CARDIOVASCULAR	**ENDOCRINE**
☐ Chest Pain or Angina	☐ Diabetes
☐ Heart Attack	Age of onset: _____
☐ Heart Failure	☐ Take Insulin
☐ Irregular Heart Beat	☐ Thyroid Disease
☐ Pacemaker	**MUSCULOSKELETAL**
☐ Clot in Lungs or Legs	☐ Arthritis
☐ High Blood Pressure	☐ Joint or Bone Implants (metal/ plastic)
☐ Heart Murmur	☐ Back or neck problems
☐ High Cholesterol	☐ Chronic Pain
☐ Rheumatic Fever	Location of pain: _____
RESPIRATORY	**NEUROLOGICAL**
☐ Smoking/ Tobacco Use	☐ Head Injury
Number of cigarettes per day: _____	☐ Stroke
Number of years smoking: _____	☐ Loss of Consciousness
Quit? If so, when? _____	☐ Loss of Sensation in Legs or Feet
☐ Emphysema or COPD	☐ Shooting Pain Down Arms or Legs
☐ Asthma	☐ Seizures/ Epilepsy
☐ Tuberculosis	☐ Migraines
☐ Recent Cold/Cough (last 2 weeks)	☐ Swallowing Difficulty
☐ Shortness of Breath (when climbing 1 flight of stairs)	☐ Dementia
GASTROINTESTINAL	☐ Alzheimer's Disease
☐ Gastrointestinal Bleeding	**MENTAL HEALTH**
☐ Liver Problems	☐ Anxiety and/ or Depression
☐ Liver Cirrhosis	☐ Other: _____
☐ Ulcers	**COMMUNICABLE ILLNESS**
☐ Frequent Nausea or Vomiting	☐ Hepatitis ☐ A ☐ B ☐ C
☐ Frequent Heart burn	☐ HIV/ AIDS
☐ Hiatus Hernia	**SENSORY/OTHER**
GENITOURINARY	☐ Vision Difficulties
☐ Kidney Problems	☐ Glasses or Contact Lenses
☐ Dialysis	☐ Hearing Difficulties
☐ Prostate Problems	☐ Hearing Aid ☐ Right ☐ Left
AIRWAY	**FAMILY HISTORY**
☐ Dentures: ☐ *Full* ☐ *Partial*	☐ Malignant Hyperthermia
☐ Caps ☐ Crowns ☐ Loose Teeth	☐ Muscular Dystrophy
☐ Difficulty Moving Head/Neck/Jaw	☐ Adverse Reaction to Anaesthetic: _____
☐ History of "Difficult Intubation"	**FEMALE PATIENTS ONLY**
BODY PIERCINGS	☐ Do you think you could be pregnant?
☐ Location(s): _____	Date of last menstrual period: _____

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Obstructive Sleep Apnea Screening	
Do you have sleep apnea?	☐ Yes ☐ No
Do you use CPAP or BiPAP? If yes, setting at?	☐ Yes ☐ No
Do you snore loudly (loud enough to be heard through a closed door)?	☐ Yes ☐ No
Do you often feel tired, fatigued or sleepy during the daytime?	☐ Yes ☐ No
Has anyone observed you stop breathing or choking/ gasping during your sleep?	☐ Yes ☐ No
Do you have, or are you being treated for high blood pressure?	☐ Yes ☐ No

Screening for Interest in Tobacco Reduction:	
Have you used tobacco in the past 6 months?	☐ Yes ☐ No
If yes, would you be willing to speak with a health care provider regarding your tobacco use while you are a patient of SJHC?	☐ Yes ☐ No

CAGE Alcohol Screening Test	
In the past year, have you had a drink containing alcohol?	☐ Yes ☐ No
If "Yes", please answer the following questions.	
Have you ever felt that you should *cut* down on your drinking?	☐ Yes ☐ No
Have people *annoyed* you by criticizing your drinking?	☐ Yes ☐ No
Have you ever felt bad or *guilty* about your drinking?	☐ Yes ☐ No
Have you had a drink first thing in the morning to steady your nerves or to get rid of a hangover *(eye-opener)*?	☐ Yes ☐ No
Give one point to each "Yes" answer to determine your total score.	Total Score: _____
Answer the following question if your Total Score is 2 or greater.	
Are you willing to speak with a health care provider regarding your alcohol use?	☐ Yes ☐ No

Home Environment (check all that apply):	
In your home do you have:	☐ Stairs – number of stairs _____ ☐ Elevator ☐ Ramp
What supports do you have at home?	☐ Family member/ Friend ☐ CCAC Services ☐ Social work ☐ Other: _____ ☐ None
Do you require assistance with any of the following?	☐ Bathing ☐ Toileting ☐ Meals ☐ Dressing ☐ Activity (walking) ☐ Housekeeping
Is there anyone at home who depends on you?	☐ Children ☐ Parents ☐ Spouse ☐ Pets ☐ Other: _____
What is your regular form of transportation?	☐ Family ☐ Self *(please indicate method of transportation)*: _____ ☐ Wheel-Trans *please indicate wheel-Trans #*: _____

Discharge Planning and Additional Information	
Has your doctor discussed expected length of stay in the hospital?	☐ Yes ☐ No
Has your doctor discussed plans for going home?	☐ Yes ☐ No
Do you have a living will/advanced directive?	☐ Yes ☐ No
Do you have a power of attorney for personal care?	☐ Yes ☐ No

Signature of Patient or Guardian:	Date: