



Patient ID

**Dear Patient:**

Please fill in the form as much as you can. Once completed, give it to your Surgeon's Office so we can arrange an appointment with the **Peanesthetic Assessment and Testing Clinic**

<b>General Information</b>																
<p>Your Name: _____  <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Last Name</span> <span>First Name</span> </div> </p> <p>Language(s) spoken: _____ Preferred Language? _____</p> <p>Do you have a preferred name? _____ Date of Birth: ( __ / __ / __ )  <div style="display: flex; justify-content: space-around; font-size: x-small;"> <span>DD</span> <span>MM</span> <span>YYYY</span> </div> </p> <p>Height: _____ Weight: _____</p> <p>Daytime Telephone Number: _____ Email: _____</p> <p><b>Surgical Procedure:</b> _____ <b>Surgeon:</b> _____</p> <p><b>Surgical Date</b> (if known): _____</p> <p><b>Who will bring you home after your surgery?</b> _____</p> <p><b>Who will stay with you overnight at home?</b> _____</p> <p>Who is your primary contact person?            Name: _____ Relationship: _____ Phone: ( __ ) _____</p> <p><b>Name of Family Doctor:</b> _____ Phone: ( __ ) _____</p>	<p style="color: red; font-weight: bold;">Hospital use only:</p> <p style="font-size: x-small;">(To be completed by PATCRN)</p>  <p style="text-align: center; font-weight: bold; color: blue; text-decoration: underline;">Vital Signs</p> <p>Date/Time: _____</p> <p>BP: _____</p> <p>Heart Rate: _____</p> <p>SpO<sub>2</sub>: _____</p> <p>Temperature: _____</p> <p>Height: _____</p> <p>Weight: _____</p>															
<b>COVID-19 Information</b>	<b>Surveillance Swabs:</b>															
<p>Have you ever tested positive for COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No            If yes, when? _____</p> <p>Have you ever been vaccinated for COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No            If yes, how many doses have you had? _____            Date of last dose _____</p>	<p>Complete "MRSA/VRE/CPE Admission Screening Tool"</p> <p><input type="checkbox"/> Not Required</p> <p><input type="checkbox"/> Sent</p>															
<b>Hospital Stay and Surgeries</b>																
<p>Have you been admitted to a healthcare facility for reasons other than surgery in the last 12 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																
<p><b>Please list all the surgeries and procedures you have had</b> (starting from most recent)</p>																
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%; text-align: left; padding: 5px;">Surgery / Procedure</th> <th style="width: 20%; text-align: center; padding: 5px;">Hospital</th> <th style="width: 20%; text-align: center; padding: 5px;">Year</th> </tr> </thead> <tbody> <tr><td style="padding: 5px;">1.</td><td></td><td></td></tr> <tr><td style="padding: 5px;">2.</td><td></td><td></td></tr> <tr><td style="padding: 5px;">3.</td><td></td><td></td></tr> <tr><td style="padding: 5px;">4.</td><td></td><td></td></tr> </tbody> </table>	Surgery / Procedure	Hospital	Year	1.			2.			3.			4.			
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\_\_\_\_\_

Please list all the surgeries and procedures you have had (starting from most recent)

Surgery / Procedure	Hospital	Year
5.		
6.		
7.		
8.		
9.		

Allergies (Complete this area below or bring a list to your appointment)

**Hospital use only:**

(To be completed by PATCRN)

Do you have allergies or intolerances (i.e. medication, latex, tape, dust/pollen, food)? .....  Yes  No

Allergic to: (please list all allergies/intolerances)

Reaction:


Seen by Pharmacist

**Medications** (please list all prescription, puffers, eye drops, blood thinners, prescription cannabis, anything you take that contains THC, non-prescription medications, any other medications, vitamin and herbal supplements)

Please bring medication in original containers to your appointment and your medication list

Name of Medication <input type="checkbox"/> I do not take any medicines	Dosage	What times do you take it? (please check)			Why do you take it?
		a.m.	p.m.	Other	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Your Pharmacy Name: \_\_\_\_\_ Pharmacy Phone Number (or Location): \_\_\_\_\_



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<b>Anesthesia History (Complete this section if you had surgery in the past)</b>	<b>Hospital use only:</b> (To be completed by PATCRN)
<p>What kind of Anaesthesia have you had? (check all that apply)</p> <p><input type="checkbox"/> General (asleep)   <input type="checkbox"/> Spinal or Epidural   <input type="checkbox"/> Nerve Block   <input type="checkbox"/> Sedative   <input type="checkbox"/> Not Sure</p> <p>Were you aware of any problems with Anesthesia? (check all that apply)</p> <p><input type="checkbox"/> Difficulty placing the breathing tube                      <input type="checkbox"/> History of postop nausea + vomiting</p> <p><input type="checkbox"/> Malignant Hyperthermia (happened to you)                      <input type="checkbox"/> Confusion after surgery</p> <p><input type="checkbox"/> Malignant Hyperthermia (in a blood relative)</p> <p>If yes, have you had testing for MH?    <input type="checkbox"/> Yes   <input type="checkbox"/> No    Results: _____</p>	<p><input type="checkbox"/> Dentures / Braces / Retainers</p> <p><input type="checkbox"/> Loose / Chipped Teeth</p>
<b>Heart Health</b>	
<p>Do you have, or have had, any heart conditions: .....                      <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p><b>If no, skip to the next section. If yes, complete this section</b></p> <p><input type="checkbox"/> Angina                      <input type="checkbox"/> Heart Attack                      <input type="checkbox"/> Heart Failure                      <input type="checkbox"/> Valve Problem</p> <p><input type="checkbox"/> Stent                      <input type="checkbox"/> Bypass Surgery                      <input type="checkbox"/> Valve Surgery                      <input type="checkbox"/> Cardiomyopathy</p> <p><input type="checkbox"/> Pacemaker                      <input type="checkbox"/> Implanted Defibrillator</p> <p><input type="checkbox"/> Congenital Heart Defect                      <input type="checkbox"/> Surgery for congenital defect: _____</p> <p><input type="checkbox"/> Arrhythmia (atrial fibrillation or rapid heartbeat): _____</p>	
<p>Do you have high blood pressure or get treatment for it? .....                      <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Have you had any recent heart tests in the last 2 years? (not ECG) (e.g. Stress test, Holter monitor, echocardiogram) .....                      <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Name of cardiologist: _____                      Phone Number: ( ____ ) _____</p>	<p><input type="checkbox"/> Bring report to PATC appointment</p> <p>or fax to <b>(416) 864 - 5732</b></p>
<b>Lungs and Breathing</b>	
<p>Have you ever had any lung or breathing conditions: .....                      <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p><b>If no, skip to the next section. If yes, complete this section</b></p> <p><input type="checkbox"/> Asthma                      <input type="checkbox"/> Pulmonary Fibrosis                      <input type="checkbox"/> Cystic Fibrosis                      <input type="checkbox"/> Sleep Apnea</p> <p><input type="checkbox"/> Sarcoidosis                      <input type="checkbox"/> COPD (emphysema, chronic bronchitis)</p> <p><input type="checkbox"/> Other: _____</p>	





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<b>Diabetes and Endocrine</b>	<b>Hospital use only:</b> <small>(To be completed by PATCRN)</small>
Do you have diabetes, thyroid, pituitary, or other endocrine disorder?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no, skip to the next section. If yes, complete this section</b> If you have diabetes, how do you manage it?... <input type="checkbox"/> Insulin <input type="checkbox"/> Diabetic pills <input type="checkbox"/> Diet only If you have thyroid problems, is it.. <input type="checkbox"/> Overactive (hyperthyroid) <input type="checkbox"/> Underactive (hypothyroid) Other gland disorders: (e.g. pituitary, adrenal, parathyroid) _____ Name of endocrinologist: _____ Phone: ( ___ ) _____	<input type="checkbox"/> Insulin pump
<b>Kidney Health</b>	
Do you have kidney disease or dysfunction (other than stones)? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no, skip to the next section. If yes, complete this section</b> Are you on dialysis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a kidney transplant? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ Name of kidney specialist: _____ Phone: ( ___ ) _____	<input type="checkbox"/> Catheter <input type="checkbox"/> Urostomy <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal Dialysis
<b>Digestive System</b>	
Have you ever had any digestive conditions?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no, skip to the next section. If yes, complete this section</b>	Special Diet / Intolerances: _____
<input type="checkbox"/> Feeding Tube <input type="checkbox"/> Heartburn / Reflux <input type="checkbox"/> Hiatus hernia (stomach) <input type="checkbox"/> Liver disease (e.g. hepatitis, jaundice) <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> Other: _____	Bowels:
Do you have difficulty eating or swallowing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	



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**Nerve and Brain System**

**Hospital use only:**  
(To be completed by PATCRN)

Have you ever had any of these neurological conditions? .....  Yes  No

**If no, skip to the next section. If yes, complete this section**

- A disease that affects your muscles/nerves (e.g. Multiple Sclerosis, Parkinson's, ALS)
- Stroke or stroke like symptoms
- Spinal cord problems (e.g. spinal stenosis)
- Seizure disorder (e.g. epilepsy)
- Fainting spells, vertigo in the past 2 years
- Neuropathy
- Other: \_\_\_\_\_
- Brain Aneurysm
- Fibromyalgia
- Dementia
- Migraines
- Alzheimer's Disease

Name of neurologist: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_

**Habits and Substance use**

Do you currently smoke cigarettes/cigars? .....  Yes  No

If yes, how long have you been smoking? \_\_\_\_\_

Approximately how many cigarettes do you smoke per day? \_\_\_\_\_

If you have quit smoking please provide the date you quit \_\_\_\_\_

Do you use any of the following substances? (Check all that apply) .....

- None
- Cannabis
- Methadone
- Suboxone

Do you use recreational drugs (e.g. cocaine, heroin, fentanyl, methamphetamine)?

If yes, please list: \_\_\_\_\_ How often: \_\_\_\_\_

Do you drink alcohol? .....  Yes  No

If yes, how much?: \_\_\_\_\_ How often: \_\_\_\_\_

Do you see an addiction specialist? .....  Yes  No

Name of specialist: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_



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**Other Important Health Information**

Is there any chance you may be pregnant? .....  Yes  No

If you are pre-menopausal, it is our policy to perform a pregnancy test on the day of surgery. Do you wish to opt out of this test for any reason?  Yes  No

Have you had cancer? .....  Yes  No

When: \_\_\_\_\_ Type: \_\_\_\_\_

What kind of treatment did you have?

Chemotherapy  Radiation  Surgery  Other: \_\_\_\_\_

Name of oncologist: \_\_\_\_\_ Phone: ( \_\_\_ ) \_\_\_\_\_

Do you have HIV? .....  Yes  No

Name of specialist: \_\_\_\_\_ Phone: ( \_\_\_ ) \_\_\_\_\_

Do you have any disability related to vision? .....  Yes  No  
(please bring glasses to all hospital appointments)

Do you wear a hearing aid? .....  Yes  No  
(please wear them to every hospital visit)

Do you have any support services in home presently? .....  Yes  No

List: \_\_\_\_\_

Please tell us about any other illness, limitations, or concern we should know about:  
\_\_\_\_\_

**Hospital use only:**  
(To be completed by PATCRN)

Wheeltrans

**Patient Questionnaire Completed By:**

\_\_\_\_\_

*Print Name*

*Signature*

*Relationship to patient*

*Date*

**Reviewed in PATC by:**

\_\_\_\_\_

*Print Name*

*Designation*

*Signature*

*Date*

*Time*