fraserhealth

PATIENT QUESTIONNAIRE
PATIENT TO COMPLETE PAGE 1 & 2

PATIENT SURNAME (legal)	FIRST NAME (legal)	Other names	DOB(d/m/yyyy)	CARE CARD#

RESIDENTIAL PHONE	BUSINESS PHONE	EXT.	CELL PHONE	SURGEON / PHYSICIAN Dr.

INTERPRETER REQUIRED? If yes, please specify name and contact phone#	HEIGHT (cm)	WEIGHT (kg)
Name: Phone #:		

What is the reason you are seeking treatment? _____

Do you have any allergies? (including latex) If yes please list. _____

_____

Have you <u>ever had</u> any of these health issues? (check appropriate boxes)

- ☐ heart attack Date: _____
- ☐ heart murmur
- ☐ fast or irregular heart beats
- ☐ heart burn/acid reflux
- ☐ high blood pressure
- ☐ stroke Date: _____
- ☐ mental or nervous disorders
- ☐ genetic/neurological problems
- ☐ emphysema/breathing problems
- ☐ asthma/hay fever
- ☐ rheumatic fever
- ☐ blood clotting disorder
- ☐ bronchitis
- ☐ tuberculosis
- ☐ kidney problems
- ☐ liver problems
- ☐ hepatitis/jaundice
- ☐ high cholesterol
- ☐ arthritis
- ☐ migraines
- ☐ glaucoma
- ☐ sleep apnea
- ☐ Do you have a CPAP machine
- ☐ pacemaker
- ☐ thyroid problems
- ☐ cancer
- ☐ epilepsy/seizures
- ☐ back/neck problems

Do you <u>presently</u> suffer from any of the following? (check appropriate boxes)

- ☐ chest pains
- ☐ confusion
- ☐ nose bleeds
- ☐ muscles cramps/weakness
- ☐ headaches
- ☐ swollen ankles
- ☐ dizzy spells
- ☐ anxiety or depression
- ☐ shortness of breath
- ☐ memory lapses
- ☐ vision problems
- ☐ difficulty opening mouth

yes	no	
☐	☐	Have you or any member of your family ever had a problem with an anesthetic? If yes, please describe. _____
☐	☐	Do you have an infectious disease? If yes, please specify. _____
☐	☐	Do you have diabetes? If yes, what do you take? _____
☐	☐	Are you pregnant? If yes, how many weeks? _____
☐	☐	Were you (the patient) born prematurely? ___ weeks.
☐	☐	Do you wear contact lenses?
☐	☐	Do you wear hearing aids?
☐	☐	Do you have loose, broken, chipped or capped teeth?
☐	☐	Do you have braces?
☐	☐	Do you have bridges? Permanent ☐ Removable ☐
☐	☐	Do you have dentures?
☐	☐	Do you smoke? If yes, how much in an typical day? _____
☐	☐	Do you take drugs? (other than prescribed by physician) if yes, list _____

PATIENT QUESTIONNAIRE Cont'd
PATIENT TO COMPLETE PAGE 2

PATIENT SURNAME (legal)	FIRST NAME (legal)	Other names	DOB(d/m/yyyy)	CARE CARD#

CONTINUED FROM PAGE 1...

Have you ever had a referral to a cardiologist (heart specialist) if yes, who _____

How much alcohol do you drink in a typical day? _____

Have you had any operations in your life? If so, please list _____

_____

*****PLEASE ATTACH A LIST or write below YOUR MEDICATIONS - INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER AND HERBAL REMEDIES (please include names and dosages of medications if possible)*****

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT/PARENT SIGNATURE: _____

DATE (d/m/yyyy):_____

Pre Admission Office Use Only

Anesthesia Consult ☐ ASA class _____

Suitable for Daycare (SDC) ☐Y ☐N

Suitable for Same Day Admit (SDA) ☐Y☐N

_____

_____