Previsit Questionnaire   PLEASE PRINT ONLY

Patient's Legal Name: _____
LAST NAME (LEGAL)   GIVEN NAMES (LEGAL)   PREVIOUS SURNAME(S)

Personal Health Care Number: _____   **Sex:** ☐ Male ☐ Female

Birthdate: Day _____ Month _____ Year _____   Marital Status: _____

Your Present Address: _____

City: _____ Province: _____ Postal Code: _____

Which Month & Year Did You Move to the Above Address? _____

Previous Address (if less than 12 months at present address): _____

City: _____ Province: _____ Postal Code: _____

Which Month & Year Did You Move to This Address? _____

Present Employer: _____ Occupation _____

Since: Month _____ Year _____

Next of Kin: Name _____ Relationship _____
LAST NAME   GIVEN NAME

Telephone: Please check the best number to contact you at.

(Home) ☐ _____   (Work) ☐ _____

(Cell) ☐ _____   (Other) ☐ _____

Is it OK to contact you on your cell phone? ☐ Yes   ☐ No

Is it OK to contact you by email?   ☐ Yes   ☐ No

(Email): _____

USE OF EMAIL IS RESTRICTED TO SCHEDULING APPOINTMENTS. Please note that no confidential information such as results will be sent by email. We will NOT respond to email with medical questions.

This section only applicable if you are admitted for surgery

Accommodation Preferred (subject to availability only): ☐ Private Room   ☐ Semi-Private Room   ☐ Standard Ward

There is a Charge for Semi & Private Rooms – Payable on Discharge

Have You Ever Been a Patient in The Richmond Hospital: ☐ No   ☐ Yes – when? _____

Urologist: _____ Family Physician: _____

Were You Born in B.C.? ☐ Yes   ☐ No   **If not, date of arrival in B.C.:** _____

Canadian Citizen? _____ **Landed Immigrant?** _____ **If Landed Immigrant**

and Have Lived in Canada Less than 1 Year, Photocopy of Immigration Papers Must be Provided Upon Admission.

Thank you for completing this questionnaire. Email, Print, Fax or Bring to your appointment.

Richmond Hospital
part of the Vancouver Coastal Health Authority

PCIS LABEL

Surgeon:_____

Patient Name:_____ Sex:_____ Date of Birth:_____

Weight:_____lbs./kgs. Height:_____in./cm.

Check [√] the correct column after each question. PLEASE COMPLETE BOTH SIDES OF THE PAGE.

	Yes	No	Not sure		Yes	No	Not sure
Do you currently have or do you have a history of:				Do you currently have or do you have a history of:			
1. Heart pain / angina				22. Kidney problems / failure			
2. Heart attack				23. Heartburn / hiatus hernia			
3. Heart murmur / heart valve problem				24. Liver disease / jaundice / hepatitis			
4. Stroke				25. Thyroid problems			
5. High blood pressure				26. Arthritis			
6. Irregular pulse				27. Bleeding disorders - yourself			
7. Circulation problems				- other family members			
8. Asthma / bronchitis / emphysema				28. Paralysis / weakness			
9. Shortness of breath with daily activity				29. Numbness of face or limbs			
10. New cough or cold				30. Seizures			
11. Chronic cough				31. Tumors / malignancy			
12. Sleep apnea or use a CPAP machine				32. Previous blood transfusion reactions			
Do you take:				33. Diabetes			
13. Pills for high blood pressure				- If **YES**, circle your treatment: diet only; insulin; pills			
14. Pills to thin your blood				34. Are you, or could you be, pregnant?			
15. Antibiotics before dental work				35. Do you have any other medical problems?			
16. Cortisone-like pills within last 6 months				Do you have:			
Do you:				Dentures	Upper	Lower	
17. Smoke tobacco? How much?				Partial plate / dentures	Upper	Lower	
18. Have you quit? When?				Capped / loose teeth			
19. Drink alcohol regularly? How much?				Hearing difficulties			
20. Take street drugs? What?				Hearing aid	Right	Left	
21. Have you or any member of your family had any problems with anesthetics?				Glasses / contact lens / lens implant / prosthetic eye	Right	Left	
Indicate who:							

If **YES** to any of the above questions, please explain: _____

_____

_____

_____

Please turn over and complete Page 2 ➡

Do you have any allergies? Yes ☐ No ☐

Allergy to	Allergic Reaction

Please list all the medications and herbal supplements you take (use a separate piece of paper if you need more space):

Medication / Supplement Name	Dose (amount taken each time)	How often do you take it?	Reason for taking

List any operations you have had:

Date: _____ Operation: _____

_____

_____

_____

_____

Is there anything else you want us to know about you?

_____

_____

_____

_____

_____

_____

Completed by (please print name): _____ **Date:** _____

If you are not the patient, what is your relationship to the patient? _____