

PREOPERATIVE EVALUATION AND MEDICAL HISTORY
TO BE COMPLETED BY PATIENT OR PREADMISSION NURSE

700-1200 Burrard Street
 Vancouver, BC V6Z 2C7
 Telephone: 604-669-6181
 Fax: 604-694-6613

Patient Name: _____

Date: _____

Do you have or ever had any of the following:	NO	YES	If YES, provide details
Have you ever had problems with anesthesia? <i>If yes, describe reaction</i>			
Close family with severe reactions to anesthesia?			
Regular tobacco use in the last 6 months? <i>If yes, how many cigarettes per day on average do you smoke, and how many years have you been a smoker?</i>			
Regular alcohol use? <i>If yes, how much per week?</i>			
Regular recreational drug use?			
Shortness of breath when walking or climbing stairs?			
Severe heartburn or acid reflux?			
Difficulty opening your mouth or bending your neck?			
Sleep apnea (stopping breathing while asleep)? <i>If yes, do you use a CPAP machine at home?</i>			
Breathing problems such as asthma or emphysema?			
Irregular heartbeats, palpitations or blackouts?			
High blood pressure?			
Severe chest pain or angina or heart attack?			
Heart surgery or pacemaker or angioplasty?			
Heart murmur or heart valve problems?			
Take antibiotics before dental work?			
Spinal cord injury?			
Epilepsy or seizures or stroke?			
Diabetes?			
Stomach ulcers?			
Liver problems, jaundice or hepatitis?			
Kidney problems?			
Bleeding disorders or blood clotting problems?			
HIV or other blood borne illnesses?			
Rheumatoid arthritis?			
Methicillin-resistant Staphylococcus aureus (MRSA)?			
Any other medical problems not already mentions?			
Could you be pregnant?			

Do you have any drug or food allergies?

No YES - pls list and describe reaction: _____

Do you have a latex allergy?

No YES - pls list and describe reaction: _____

Do you take any medication?

No YES - pls list name & dosage: _____

Have you ever been seen by one of the following specialist doctors?

Respirologist Name: _____
 Cardiologist Name: _____
 Neurologist Name: _____

When & Where: _____
 When & Where: _____
 When & Where: _____

Have you ever had one of the following tests?

Sleep study (obstructive sleep apnea test) When & Where: _____
 Lung (Pulmonary) function test When & Where: _____
 Exercise stress test When & Where: _____
 Nuclear medicine heart scan (MIBI) When & Where: _____
 Heart catheterization (angiogram) When & Where: _____
 Heart echo test (ultrasound) When & Where: _____
 Holter Monitor When & Where: _____

HEIGHT _____

WEIGHT _____