



Capital Health

Queen Elizabeth II
Health Sciences Centre

Same Day Surgery Program

PATIENT HEALTH HISTORY QUESTIONNAIRE

Note: Patient must complete and return to his/her doctor prior to leaving office. If you do not understand any of the following, ask your doctor.

1.	Do you have someone to take you home and stay with you after surgery? If you answered no, you must make these arrangements.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	Have you had a physical examination by your family doctor in the last year?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	Have you ever had a heart attack? If so when?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	Please mark if you ever had <input type="checkbox"/> heart trouble, <input type="checkbox"/> skipped heart beat, <input type="checkbox"/> murmur, <input type="checkbox"/> pacemaker?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5.	Please mark if you ever had <input type="checkbox"/> angina, <input type="checkbox"/> chest pain, <input type="checkbox"/> chest tightness/heaviness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6.	Do you have high blood pressure?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7.	Do you have trouble breathing when you lie flat?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8.	Please mark if you ever had <input type="checkbox"/> asthma, <input type="checkbox"/> bronchitis, <input type="checkbox"/> emphysema?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.	Do you get short of breath climbing one flight of stairs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10.	Please mark if you ever had <input type="checkbox"/> liver disease, <input type="checkbox"/> jaundice, <input type="checkbox"/> hepatitis as an adult?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11.	Please mark if you ever had <input type="checkbox"/> indigestion, <input type="checkbox"/> heartburn, <input type="checkbox"/> hiatus hernia, <input type="checkbox"/> acid reflux?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12.	Do you have diabetes? Diet or medication controlled?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13.	Do you have any history of thyroid problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14.	Have you taken steroid-like drugs in the past year?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15.	Do you have kidney problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
16.	Please mark if you ever had <input type="checkbox"/> epilepsy <input type="checkbox"/> seizures <input type="checkbox"/> stroke <input type="checkbox"/> migraine headaches?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17.	Do you have rheumatoid arthritis? If so how long?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
18.	Do you have a blood clotting disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19.	Do you or a family member have a major bleeding disorder? ie prolonged bleeding from cuts, dental extractions.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20.	Have you or members of your family had problems with anaesthetics (other than nausea/vomiting)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
21.	Do you have trouble opening your mouth fully or problems with your jaw joints?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
22.	Do you have any other serious medical problems? Please specify:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
23.	Is there any chance you could be pregnant? Date LMP _____ Date of last pregnancy _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
24.	How many cigarettes do you smoke per day?		
25.	How much alcohol do you drink per week?		
26.	List your allergies(food, medication, latex, other):		
27.	List your medications (including over the counter drugs, pain pills, blood thinners, puffers, and insulin):		
28.	Have you had surgery in the last 5 years at the VG or Halifax Infirmary?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
29.	List any operations you have had:		
30.	Have you had any previous blood transfusions?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
31.	Known antibodies? Please specify _____		
32.	Have you had any transfusion reactions?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Completed by: _____

If not patient, state relationship

Name of Patient (please print): _____

Date (YY/MM/DD)

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