New Nouveau Brunswick Health/Santé

NEW BRUNSWICK PRESURGICAL QUESTIONNAIRE

Please fill out the front and back of this form

Patient Name: _____
Medicare Number : _____

Address :

Daytime/ work phone : _____
Cell number : _____
Home phone: _____

Date of Birth: _____ (yy/mm/dd)
Height : _____
Weight : _____

Family Doctor:

Surgeon :
Dr. Jayson Dool

Who completed this form? Patient ☐
Other ☐ Name/ relationship : _____
Date completed (yy/mm/dd) _____

1. Do you smoke? YES ☐ NO ☐
2. Have you ever smoked? YES ☐ NO ☐ How many per day? _____ Number of years you have smoked? ____
3. Is it possible that you are pregnant? YES ☐ NO ☐
4. Do you take warfarin, coumadin, aspirin, or Plavix or any blood thinner? YES ☐ NO ☐
5. Have you taken prednisone, cortisone, or steroids in the past 12 months? YES ☐ NO ☐

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?

	YES	NO		YES	NO
6. Difficulty with neck movement or opening your mouth?	☐	☐	19. Blackouts or fainting spells in the last year?	☐	☐
7. Capped, loose, or false teeth or body piercings?	☐	☐	20. Stroke, mini-stroke, severe muscle weakness, or paralysis of any part of your body?	☐	☐
8. Asthma, bronchitis, COPD, TB?	☐	☐			
9. Chronic or troublesome cough?	☐	☐	21. Epilepsy, seizure, or a significant neurological disorder?	☐	☐
10. Shortness of breath at rest or when lying flat?	☐	☐	22. Thyroid problems?	☐	☐
			23. Diabetes?	☐	☐
11. Sleep apnea (stop breathing in your sleep)?	☐	☐	24. Yellow jaundice, hepatitis, AIDS, or liver problems?	☐	☐
12. Shortness of breath when walking up two flights of stairs?	☐	☐	25. Rheumatoid arthritis (not osteoarthritis)?	☐	☐
13. Nausea or vomiting after an anesthetic?	☐	☐	26. Bruise or bleed excessively?	☐	☐
14. a) An unusual or serious reaction to any kind of anesthetic?	☐	☐	27. Leg or lung blood clots or DVT?	☐	☐
b) Does this apply to anyone else in your family?	☐	☐			
15. Heart problems such as heart murmur, valve replacement, or serious rhythm disorder?	☐	☐	28. Current low blood count, current anemia, or other blood disorder?	☐	☐
16. Angina or heart attack?	☐	☐	29. Chronic or acute pain requiring prescription medication?	☐	☐
17. Chest pain with exercise?	☐	☐	30. Hiatus hernia or significant problems with stomach acid or heartburn?	☐	☐
18. High blood pressure?	☐	☐	31. Kidney disease?	☐	☐

32. Do you drink alcohol, wine, or beer? YES ☐ No ☐
How much? _____ How often? _____

33. Do you use recreational drugs? YES ☐ No ☐
Type _____ How often? _____

34. Have you been exposed to MRSA or VRE in the past 12 months? YES ☐ No ☐

35. Who will drive you home and stay with you after discharge from the hospital?
Name/relationship: _____

36. List any major illnesses (including psychological) or operations you have had: Include where and when you had the operation

_____

_____

_____

37. When was the last time you were in the hospital? _____
Where? _____ Why? _____

38. When was the last time you had a general anesthetic? _____
What hospital? _____

39. Are you allergic to latex? NO ☐ YES ☐ Reaction:

40. List all allergies you have: (Please ask for an extra form if there is not enough room to complete your list below)

Allergic to:	Reaction:

41. List all medications you take including herbal and over the counter: (Please ask for an extra form if there is not enough room to complete your list below)

DRUG	DOSE	How often	Reason

HOSPITAL USE ONLY BELOW THIS LINE:

Reviewed by _____ Date _____

Phone assessment required YES _____ NO _____ Appointment scheduled YES ____ NO _____