HAVE YOU EVER HAD:	Yes	No	HAVE YOU EVER HAD	Yes	No	ARE YOU NOW TAKING, OR HAVE YOU EVER TAKEN, ANY OF THE FOLLOWING	Yes	No
Diabetes			Shortness of breath			Aspirin (within 10 days)		
Heart Attack			COPD			Blood Thinners		
Angina or Chest Pain			Emphysema			Water Pills		
Irregular Heart Beats			Asthma			Digoxin / Heart Pills		
High Blood Pressure								
Pacemaker			Recent Fever, Chills, Flu, Cold or Pneumonia in past 7 days			Are you a smoker		
Internal Defibrillator						# per day		
Pins and/or Plates								
Rheumatic Fever or Heart Murmur								
Swelling of Ankles			TB			Alcohol Use		
Anemia			Epilepsy			Amount		
Blood Transfusions			Stroke			How often		
Reactions to Blood			Numbness or Weak Limbs					
Bleeding Problems			Fainting Spells					
H.I.V. Exposure			Kidney Trouble			Dentures		
Malignant Hyperthermia			Jaundice, Hepatitis or Cirrhosis					
Sleep Apnea – Wears CPAP								
			Hiatus Hernia					

MEDICAL PROBLEMS NOT LISTED ABOVE	LIST PREVIOUS SURGERIES SURGERY:	HOSPITAL	DATE

MEDICATIONS

ARE YOU TAKING ANY:	YES	NO
Prescription Drugs		
Street Drugs		
Over the Counter - Vitamins, herbals		

HAVE YOU OR ANY RELATIVE HAD A PROBLEM WITH ANAESTHETICS? _____YES _____NO
RELATIONSHIP? _____

CURRENT MEDICATIONS	DOSAGE	CURRENT MEDICATIONS	DOSAGE

PLEASE BRING ALL OF YOUR MEDICATIONS IN THEIR ORIGINAL CONTAINER INCLUDING INSULIN

MEDICATION ALLERGIES	OTHER ALLERGIES		
	Adhesive (e.g. tape)	Yes ☐	No ☐
	Latex (e.g. rubber gloves)	Yes ☐	No ☐
	Iodine	Yes ☐	No ☐

ROSS MEMORIAL HOSPITAL

10 Angeline Street North
Lindsay, ON K9V 4M8

PREOPERATIVE QUESTIONNAIRE

Please complete fully prior to your Preoperative Assessment appointment

Patient's Name: _____

Emergency Contact - Day of Surgery _____

Upon arrival to the outpatient department, please have the person responsible for driving you home after your surgery, check with the outpatient nurse for a timeframe for your pick-up.