Covenant Health
Compassionate care led by Catholic values

Grey Nuns Hospital Pre-Operative Database

1. **Reason** for appointment: _____
2. Please check the following **Health History** questions if yes and provide detail:

NEUROLOGICAL/MUSCULOSKELETAL
☐ Blackouts or fainting How often:
☐ Stroke/TIA When:
☐ Epilepsy/Seizure disorder How often:
CARDIAC
☐ High Blood Pressure When:
☐ Heart Attack When:
☐ Chest Pain/Angina When:
☐ Other heart conditions (ex. Heart valve, pacemaker, internal cardiac defibrillator) Type:
RESPIRATORY
☐ Lung problem (ex. Asthma, COPD, shortness of breath) What/when:
☐ Require a puffer/inhaler to breath better How often:
☐ Sleep apnea or chronic snoring
☐ CPAP machine (used at home or told to use)
☐ Breathing test When:
☐ Smoker (including e-cigarettes and marijuana) Cigs/day: # of years:
☐ Past smoker Quit date: # of years:
☐ Home oxygen use
HEMATOLOGICAL
☐ Blood clots (DVT, pulmonary embolism) When:
☐ Bleeding disorders What:
☐ Anemia When:
GASTROINTESTINAL/GENITOURINARY
☐ Hepatitis or liver condition Type:
☐ Reflux of food or acid/heartburn How often:
☐ Kidney condition Type:
ENDOCRINE
☐ Diabetes: ☐ Insulin ☐ Tablet ☐ Diet controlled
☐ Thyroid What:
GENERAL
☐ Exercise How much: /times per week
☐ Drink alcohol How much: /day /week
☐ Use recreational drugs Type: How often:
☐ Condition that runs in your family (ex. Thalassemia/muscle dystrophy) What:
☐ Anesthetic problems (self or family history) What:
☐ History of cancer Type, treatment eg. radiation/chemo When:
☐ Previous blood transfusion When: Reaction: ☐ yes ☐ no
☐ Any infectious disease (ex. MRSA/HIV/TB) What:
☐ Communication barrier ☐ Deaf ☐ Blind ☐ Other: ☐ Language spoken at home other than English: ☐ Interpreter required
☐ Mental health conditions What:
☐ Pregnant Due date:

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HEALTH HISTORY PART 2

Are you or your family concerned about new problems with your memory?	☐ No	☐ Yes	
Have you been diagnosed with dementia, Alzheimer's disease, or a major neurocognitive disorder?	☐ No ☐	☐ Yes	
In the past year, how many times have you been admitted to a hospital?	☐ 0	☐ 1-2	☐ >2
In general, how would you describe your health?	☐ Excellent ☐ Very Good ☐ Good	☐ Fair	☐ Poor
With how many of the following activities do you require help? ☐ Meal preparation ☐ Taking medications ☐ Shopping ☐ Transportation ☐ Telephone ☐ Laundry ☐ Housekeeping ☐ Managing Money	☐ 0-1 ☐	☐ 2-4	☐ 5-8
When you need help is there someone who you can count on who is willing and able to meet your needs?	☐ Always	☐ Sometimes	☐ Never
Do you use 5 or more prescription medications on a regular basis?	☐ No	☐ Yes	
At times have you forgotten to take your prescription medications?	☐ No	☐ Yes	
Have you recently lost weight such that your clothing has become loose?	☐ No	☐ Yes	
Do you often feel sad or depressed?	☐ No	☐ Yes	
Do you have a problem with losing control of urine when you don't want to?	☐ No	☐ Yes	
Does your baseline health now limit you in the following? ☐ Vigorous activities around the house ☐ Climbing stairs ☐ Walking several blocks	☐ Not limited at all	☐ Limited a little	☐ Limited a lot

ALLERGIES – Be prepared to discuss allergies and reactions upon admission

MEDICATIONS – Please attach list (printed or handwritten)

OTHER

Patient/Designate Signature: _____Date: _____

----------STAFF USE ONLY----------

AWOL-S Screening

☐ over 75 ☐ spelled WORLD backwards incorrectly ☐ Disoriented to place ☐ ASA 3/4 Surgery Risk: ☐ 0 ☐ 1 ☐ 2 TOTAL

COMMENTS

Reviewed by: _____Date: _____