Saskatchewan Health Authority

Pre-Admission Patient Recorded Surgical History

Complete the health history as best you can. Check "yes" or "no". If you are not sure of any answer, check "unsure". Use the notes section to add more information.

SURGEON OFFICE: Submit this form with OR Booking Package

Date: _____

PATIENT INFORMATION			
Name (as it appears on your health card):	Pronouns: Sex at birth: ☐ Male ☐ Female	Date of birth (mm/dd/yyyy):	
Phone: E-mail:	Address (including postal code):		
Family care provider:	Height: ___ ft ____ in **or** _____ cm	Weight: _____ lb **or** _____ kg	
Allergies:			
Do you speak English? ☐ Yes ☐ No	If no, what is your first language?		
Do you have memory problems or confusion? ☐ No ☐ Yes:			
Are you significantly hard of hearing? ☐ No ☐ Yes			
Have you been seen by a heart specialist? ☐ No ☐ Yes: Dr. _____ Have you been seen by a lung specialist? ☐ No ☐ Yes: Dr. _____ Have you been seen by a kidney specialist? ☐ No ☐ Yes: Dr. _____ Have you been seen by a hematologist? ☐ No ☐ Yes: Dr. _____ Have you been seen by any other specialists for your health? ☐ No ☐ Yes (name and specialty):			

HEART HISTORY				
Do you have **OR** have you ever had:	Yes	No	Unsure	Notes:
Do you get chest pain with activity?				
Irregular heart beat? (AFib, SVT, etc.)				
Have you ever fainted (not related to standing up too quickly) or had an unexplained fall in the last year?				
High blood pressure?				
A pacemaker or implantable cardioverter defibrillator (ICD)?				
Heart valve disease?				
A cardiac stent? If yes, when?				
Heart failure?				
Trouble breathing when laying flat?				
A known cardiomyopathy?				
Peripheral vascular disease?				
A stroke or TIA?				
BREATHING HISTORY				
Home oxygen?				
Severe COPD?				
Asthma that required emergency room or hospital admission in past 12 months?				
Sleep apnea? If yes, do you use a CPAP machine?				
ANEMIA SCREENING				
Have you ever had a low iron blood test result?				
Have you ever received a blood transfusion or iron by pill, injection or infusion?				

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Name:	Date of Birth (mm/dd/yyyy):

OTHER IMPORTANT HEALTH INFORMATION				
Do you have **OR** have you ever had:	Yes	No	Unsure	Notes:
Cancer? If yes, are you receiving chemotherapy?				
Liver disease? If yes, explain in notes.				
On average do you drink **more** than the following alcoholic beverages per week: **Male:** 21 or more drinks? **Female:** 14 or more drinks?				
Kidney disease? If yes, explain in notes. Are you on dialysis? If yes, where?				
Diabetes?				
Thyroid disease?				
Other endocrine disease (Addison's Cushing's, etc.)? If yes, what?				
Rheumatoid arthritis?				
Ankylosing spondylitis?				
Bleeding or clotting disorders? If yes, explain in notes.				
Neuromuscular disorders (myasthenia gravis, spinal cord lesion, multiple sclerosis, etc.)? If yes, explain in notes.				
Malignant hyperthermia? Do any of your blood relatives have a history of malignant hyperthermia?				
Difficult intubation, throat cancer or radiation of the neck? If yes, explain in notes.				
Any other health issues? If yes, explain in notes.				

MEDICATIONS				
	Yes	No	Unsure	Notes:
Do you take aspirin (ASA) regularly? If yes, explain why in notes.				
Do you take blood thinners (warfarin, dabigatran, rivaroxaban, clopidogrel, etc.)? If yes, explain why in notes.				

SURGICAL HISTORY

List all surgeries that you have had and when they were performed:

Completed by: _____ _____

Printed Name Signature

Relationship to patient: ☐ Self or _____