INSTITUT
DE CHIRURGIE
LAUNGANI

IDENTIFICATION FORM

Last Name _____ Name _____

Pronouns: ☐ She. ☐ They. ☐ He. ☐ Other: _____ Date of Birth _____

Preferred language of communication: ☐ French ☐ English ☐ Other: _____
☐ Check if an interpreter is required.

Health Insurance Number _____ Expiration Date _____

Full legal name as shown on card _____ Issuing Province _____

CONTACT INFORMATION

Street Number _____ Apt. _____ Street _____

City _____ Province _____ Postal Code _____ Country _____

Cell phone _____ Home Phone _____ Email Address _____

EMERGENCY CONTACT

Last Name _____ Name _____

Relationship _____ Cell phone _____ Email Address _____

Please complete this questionnaire to help facilitate the coordination and organization of your care with other healthcare professionals.

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PREOPERATIVE MEDICAL QUESTIONNAIRE

Last Name: _____ Name: _____

1. INFORMATION

Planned surgery(ies): _____

- Age _____ year
- Height _____ ☐ ft / ☐ cm
- B.P. _____
- Weight _____ ☐ lbs / ☐ kg
- BMI _____ kg/ m²
- Pulse _____

Do you have:

☐ Yes ☐ No Dentures / Crowns / Bridges?
☐ Yes ☐ No Hearing aid
☐ Yes ☐ No Contact lenses

2. MEDICAL HISTORY

Known medical conditions (treated):

_____
_____
_____

Known medical conditions (untreated):

_____
_____
_____

Previous surgery(ies):

☐ Yes ☐ No If yes, please specify:_____

3. MEDICATIONS

Medicaments

1. _____
2. _____
3. _____
4. _____
5. _____

Natural Products / Supplements

1. _____
2. _____
3. _____
4. _____
5. _____

Do you take:

☐ Yes ☐ No Blood thinners If yes, which ones: _____
☐ Yes ☐ No Aspirin.

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4. ANESTHESIA

Have you ever had anesthesia?

☐ Yes ☐ No General anesthesia
☐ Yes ☐ No Regional anesthesia
☐ Yes ☐ No Local anesthesia
☐ Yes ☐ No Have you experienced postoperative nausea/vomiting?
☐ Yes ☐ No Have you (or a family member) ever experienced complications related to anesthesia?
If yes, please specify: _____

5. ALLERGIES

☐ Yes ☐ No Medications Specify: _____
☐ Yes ☐ No Latex Specify: _____
☐ Yes ☐ No Foods Specify: _____
☐ Yes ☐ No Food intolerances Specify: _____

6. LIFESTYLE HABITS

☐ Yes ☐ No Tabacco Quantity / day: _____ If stopped, since when: _____
☐ Yes ☐ No Alcohol Quantity / day: _____
☐ Yes ☐ No Drugs Type / Frequency: _____

Diet:

☐ Yes ☐ No Vegetarian
☐ Yes ☐ No Vegan
☐ Other Specify: _____

7. RECENT CONDITIONS

☐ Yes ☐ No Is it possible that you are pregnant?
☐ Yes ☐ No Cold / flu within the last month
☐ Yes ☐ No Have you taken oral cortisone within the past 12 months?
☐ Yes ☐ No Have you ever received chemotherapy or radiation therapy?
☐ Yes ☐ No Have you been hospitalized for more than 24 hours within the past year?
If yes, reason and where: _____

8. CARDIAC SYSTEM

Do you have heart-related problems?

☐ Yes ☐ No Chest pain (Angina)
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Palpitations / Arrhythmia
☐ Yes ☐ No Hypertension (High blood pressure)
☐ Yes ☐ No History of heart attack
☐ Yes ☐ No Heart failure
☐ Yes ☐ No Valvular disease (heart murmur)
☐ Yes ☐ No Do you have a pacemaker?
If yes, which type: ☐ Permanent pacemaker ☐ Defibrillator pacemaker

9. RESPIRATORY SYSTEM

Do you have lung-related problems?

☐ Yes ☐ No Asthma
☐ Yes ☐ No Bronchitis
☐ Yes ☐ No Pneumonia
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Cough/phlegm
☐ Yes ☐ No Pulmonary embolism
☐ Yes ☐ No Sleep apnea
☐ Yes ☐ No CPAP/ Home oxygen
☐ Yes ☐ No Tuberculosis

10. NEUROLOGICAL SYSTEM

Do you have neurological problems?

☐ Yes ☐ No Epilepsy / Seizures
☐ Yes ☐ No Paralysis / Stroke
☐ Yes ☐ No Numbness
☐ Yes ☐ No Loss of consciousness
☐ Yes ☐ No Migraine
☐ Yes ☐ No Back pain
☐ Yes ☐ No Neck problems
☐ Yes ☐ No Spinal surgery

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11. DIGESTIVE SYSTEM AND LIVER

Do you have digestive problems?

☐ Yes ☐ No Acid reflux
☐ Yes ☐ No Stomach ulcer
☐ Yes ☐ No Liver disease (cirrhosis, hepatitis, jaundice)?
If yes, please specify: _____

12. BLOOD

Do you have blood-related problems?

☐ Yes ☐ No Anemia
☐ Yes ☐ No Abnormal bleeding
☐ Yes ☐ No Easy bruising
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Leukemia
☐ Yes ☐ No Thrombophlebitis
☐ Yes ☐ No Have you ever received a blood transfusion?
☐ Yes ☐ No Have you ever had a reaction to a transfusion?
If yes, please specify: _____

13. OTHER CONDITIONS

Do you suffer from:

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Thyroid disease
☐ Yes ☐ No Kidney disease
☐ Yes ☐ No Adrenal gland disease
☐ Yes ☐ No Pituitary gland disease
☐ Yes ☐ No Rheumatoid arthritis
☐ Yes ☐ No Muscle disease
☐ Yes ☐ No Scoliosis
☐ Yes ☐ No Motion sickness
☐ Yes ☐ No Urinary infection
☐ Yes ☐ No Genital infection (herpes, etc.)
☐ Yes ☐ No HIV infection
☐ Yes ☐ No Hepatitis infection Hepatitis: ☐ A ☐ B ☐ C
☐ Other Specify: _____

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14. FUNCTIONAL CAPACITY

Other questions related to your health condition:

☐ Yes ☐ No Do your ankles swell?

☐ Yes ☐ No Do you experience leg cramps when walking?

☐ How long can you walk without stopping?
Specify: _____

☐ How many flights of stairs can you climb?
Specify: _____

15. CARE NETWORK

☐ Yes ☐ No Are you followed at a hospital?
Specify: _____

☐ Yes ☐ No Are you followed at a CLSC (Québec)?
Specify: _____

☐ Pharmacy: _____ _____
Phone Number

16. SIGNATURE

Patient Signature: _____ Date: _____

17. VERIFICATION (CLINIC)

Verified by: _____ Date: _____