Centre intégré universitaire
de santé et de services sociaux
du Nord-de-l'Île-de-Montréal

CNM24008

Record No.		
Last name		
First name		
DOB	MIN	Exp.
Classification :		

PREOPERATIVE INFORMATION COLLECTION

To avoid having your surgery delayed, please fill out this form and return it within 48 hours.	
Hôpital du Sacré-Cœur de Montréal 5400 Gouin Blvd. West Montréal (Québec) H4J 1C5 Door G-1105 UAMI, room G-1175	***collectepreop.cnmtl@ssss.gouv.qc.ca***

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COMPLETED ON : YYYY/MM/AA

PERSONAL INFORMATION :

Last name : _____

First name : _____

Health Insurance Number : _____ Expiry date : YYYY/MM

Email address to which we can send you documentation: _____

Age : _____ Sex : ☐ F ☐ M

Languages spoken : ☐ French ☐ English ☐ Other : _____

If required, name of interpreter : _____ Tel. : _____

Your family physician's name : _____ Tel. : _____

In the past six months, have you gone to the emergency room or been hospitalized? ☐ No ☐ Yes

If yes, please indicate the name of the hospital and why you were admitted :

Name of hospital : _____

Reason : _____

_____

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	GENERAL INFORMATION	NO	YES
1	Have you previously undergone surgery? If yes, what type? _____ What year : YYYY _____ What year : YYYY _____ What year : YYYY		
2	Do you have any allergies/intolerances (medication, food, seasonal)? Allergy : _____ Reactions : _____ Allergy : _____ Reactions : _____ Allergy : _____ Reactions : _____		
3	Are you taking any over-the-counter natural products, supplements or medications ? If yes, please name them? _____ _____		
4	Are you taking any prescription medication? If yes, attach your list of medications. Name of your pharmacy : _____ Tel. : _____ I authorize my pharmacy to fax my pharmaceutic profile (list of medications) to the preoperative assessment clinic of the CIUSSS du Nord-de-l'Île de Montréal. Last name : _____ Signature : _____ Date : YYYY/MM/DD		
5	Do you use a dosette or a Dispill pill dispenser?		
6	Do you have a history of nausea or vomiting after surgery?		
	Do you suffer from travel sickness?		
7	Are you a woman who is ☐ Pregnant ☐ Breast feeding ☐ Post-Partum		

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	ANESTHESIA	NO	YES
8	Have you ever been administered local or general anesthesia (put to sleep or numb)?		
	If Yes, have you ever been told that it was difficult to intubate you?		
9	Have you, or a member of your family, had problems with anesthesia? If yes, please explain: _____		
10	Do you have problems moving your neck or opening your mouth?		
11	Have you ever had radiotherapy treatments in the neck or face region?		
12	Do you have any cervical limitations?		

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	CARDIOLOGY	NO	YES
13	Do you have a heart specialist (cardiologist)? Name : _____ tel : _____		
14	Do you have high blood pressure?		
15	Do you have heart problems? ☐ Angina ☐ Infarction ☐ Left/right heart failure ☐ Acute pulmonary edema (fluid on the lungs) ☐ Congenital malformation ☐ Heart valve disease ☐ Palpitations ☐ Heart murmur ☐ Other: _____		
16	Have you ever undergone: ☐ Heart bypass ☐ Dilatation with or without insertion of a stent? ☐ Heart valve replacement: when was it last checked? _____ ☐ Pacemaker: when was it last checked? _____		
17	Do you experience chest pain when you are active or resting?		
18	Do you experience shortness of breath or dizziness in abnormal situations or with the slightest exertion?		
19	Have you ever suffered a stroke or a mini-stroke (transient ischemic attack or TIA)?		
20	Are you currently taking anticoagulant medication? ☐ Coumadin© ☐ Xarelto ☐ Eliquis ☐ Pradaxa ☐ Other _____		
21	Are you taking any antiplatelet medication? ☐ Aspirin ☐ Plavix ☐ Other: _____		

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	ENDOCRINOLOGY	NO	YES
22	Do you have a specialist for your endocrine symptoms (endocrinologist)? Name : _____ tel : _____		
23	Do you have any problems with your thyroid gland? ☐ Hypothyroidism ☐ Hyperthyroidism		
24	Are you diabetic ? ☐ Type 1 ☐ Type 2 Specify how it is treated : ☐ Diet ☐ Hypoglycemic agent (tablet) ☐ Insulin		
25	Do you suffer from a severe endocrine disorder? ☐ Adrenal failure/Cushing's disease ☐ Hypopituitarism ☐ Hyperaldosteronism ☐ Other : _____		
26	In the past six months, have you ever taken cortisone (Prednisone) in tablet form for more than two weeks or been administered intravenous cortisone treatment??		

	RESPIRATORY	NO	YES
27	Do you have a lungs specialist (respirologist)? Name _____ tel : _____		
28	Do you suffer from respiratory problems? ☐ Asthma ☐ Chronic bronchitis ☐ Emphysema ☐ Other : _____ Provide the date of your last asthma attack: _____		
29	Do you use an inhaler (puffer)? ☐ Puffer as needed ☐ Puffer every day		
30	Do you have sleep apnea?		
31	Do you use a CPAC (sleep device)?		
32	Do you snore so loud that someone in another room can hear you snore?		
33	Has anyone ever told you that you stop breathing while you are sleeping?		

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	KIDNEYS/UROLOGY	NO	YES
34	Do you have a kidney specialist (nephrologist or urologist)? Name: _____ Tel.: _____		
35	Do you have any of these kidney problems? ☐ Infection ☐ Chronic failure ☐ Kidney stones ☐ Other: _____		
36	Are you undergoing hemodialysis? If yes, provide your treatment schedule: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday Location: _____ Tel.: _____		

	GASTROINTESTINAL	NO	YES
37	Do you have a specialist for your digestive symptoms (gastroenterologist)? Name: _____ Tel.: _____		
38	Do you have stomach, liver or intestinal problems? ☐ Liver failure ☐ Cirrhosis of the liver ☐ Ulcerative colitis: when was your last flareup? _____ ☐ Crohn's disease: when was your last flareup? _____ ☐ Other: _____		
39	Do you have gastric reflux?		

	INFLAMMATORY/IMMUNE DISEASE	NO	YES
40	Do you suffer from: ☐ Inflammatory arthritis ☐ Rheumatoid arthritis ☐ Psoriatic arthritis ☐ Ankylosing spondylitis ☐ Scleroderma ☐ Systemic lupus erythematosus ☐ Vasculitis ☐ Collagenosis ☐ Temporal arteritis ☐ Other: _____		
41	Do you suffer from a confirmed immune deficiency?		
42	Have you ever undergone an organ transplant (e.g. liver, kidney)? If yes, indicate the organ: _____		

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	NEUROLOGY	NO	YES
43	Do you have a specialist for your neurological problems (neurologist)? Name: _____ Tel.: _____		
44	Do you suffer from a neurologic or muscle disease? ☐ Epilepsy: when was your last epileptic seizure: _____ ☐ Muscular dystrophy ☐ Myasthenia gravis ☐ Steinert's disease ☐ Parkinson's disease ☐ Multiple sclerosis ☐ Other: _____		

	HEMATOLOGY	NO	YES
45	Do you have a blood specialist (hematologist)? Name: _____ Tel.: _____ Are you or have you ever been under the care of an oncologist? Name: _____ Tel.: _____		
46	Do you suffer from a hematological (blood) disease? ☐ Leukemia ☐ Myelodysplastic syndrome ☐ Thrombophilia ☐ Anemia ☐ Sickle cell disease ☐ Other: _____		
47	Do you suffer from a hemorrhagic disease? (Factor VIII, Von Willebrand disease, etc.)?		
48	Are you a carrier of ☐ Hepatitis ☐ HIV _____		
49	Have you ever suffered from phlebitis or pulmonary embolism? (blood clots in the legs or lungs) ☐ After surgery or ☐ Related to another health problem		
50	Have you ever had abnormal bleeding during: ☐ Dental appointments ☐ Minor injuries ☐ Surgery		
51	Have you ever had a blood transfusion or been administered other types of blood products (plasma, platelet, albumin)? If yes, why: _____ Have you had a reaction? If yes, describe: _____		

	PSYCHOLOGICAL CONDITION	NO	YES
52	Are you under the care of a mental health specialist? ☐ Psychiatrist ☐ Psychologist Name: _____ Tel.: _____		
53	Do you suffer from any of the following? ☐ Depressive disorders ☐ Anxiety disorders ☐ Bipolar disorder ☐ Schizophrenia spectrum disorder ☐ Other: _____		
54	In general, do you feel stressed, anxious or are you prone to panic attacks?		

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	CONSUMPTION HABITS	NO	YES
55	Do you smoke? Il yes, how many cigarettes per day? _____ At what age did you start smoking? _____ Have you ever thought about quitting? _____		
	If you have already quit, when did you quit? _____		
56	Do you drink alcohol? If yes, how many drinks per week? : _____		
	Have you ever thought about quitting?		
57	Do you use : ☐ Marijuana ☐ Narcotics ☐ Methadone : ☐ To relieve your pain or ☐ To treat your addiction ☐ Other drug : _____ If yes, how many consumption per week? : _____		
	Have you ever thought about quitting?		

	PAIN	NO	YES
58	Do you suffer from pain? If yes, indicate type of pain : ☐ Acute ☐ Chronic ☐ Cancer-related Localisation of the pain : _____ Who treats you for your pain? ☐ Family doctor ☐ Pain specialist		

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YOUR NORMAL HEALTH CONDITION

	AUTONOMY/MOBILITY	NO	YES
59	Do you need someone to help you when you are walking inside?		
60	Do you need someone to help you with getting out of bed at home?		
61	Do you use a walking aid? If yes, please specify type: ☐ Cane ☐ Walker ☐ Crutches ☐ Rollator ☐ Orthotic device ☐ Prosthetic device ☐ Wheel chair ☐ Motorized wheel chair ☐ Other : _____		
	Do you know how to use it?		
62	Do you need someone to help you with eating at home?		
63	Do you need someone to help you with getting to and from the toilet at home?		
64	Do you need any equipment to use the toilet at home? ☐ Commode chair ☐ Basin ☐ Urinal		
65	Do you need someone to help you with bathing or showering at home? If yes, who helps you? ☐ Spouse ☐ Child(ren) ☐ CLSC ☐ Other : _____		
66	Do you need someone to help you with brushing your teeth?		
67	Do you need someone to help you with getting dressed?		
68	Do you have trouble making certain movements? Indicate movements: _____		
69	Have you ever fell down in the past year? Amount of times: _____ Occasion : _____		
70	Have you reduced your activities because you were afraid of falling?		

	INTEGRITY/SKIN	NO	YES
71	Do you have any unhealed wounds?		
72	Do you have a tattoo, or an implant, piercing, joint prosthesis, orthodontic device or any other metal object?		
73	Do you suffer from venous insufficiency?		

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	NUTRITION/HYDRATION	NO	YES
74	Do you need help with meal preparation?		
75	Do you wear dentures? ☐ Upper: ☐ Full/ ☐ Partial ☐ Lower: ☐ Full/ ☐ Partial		
76	Are you on a special diet? If yes, specify: _____		
77	Do you cough after drinking or eating?		
78	Do you have difficulty or pain when you swallow?		
79	In the past six months, have you lost weight without trying to lose this weight? (If you put the weight back on afterwards, check no) ☐ Over 5 lb. ☐ Over 10 lb.		
	Have you been eating less than usual for more than one week? Reasons: _____		

	ELIMINATION	NO	YES
80	Do you have difficulty holding your urine? ☐ Occasionally ☐ Often ☐ Always		
81	Do you get up during the night to urinate?		
82	Do you have difficulty or pain when you urinate?		
83	Do you have a catheter?		
84	Do you have an ostomy?		
	If yes, are you autonomous for your ostomy care?		
85	Do you have difficulty holding your stools? ☐ Occasionally ☐ Often ☐ Always		
86	Do you use protection against incontinence at home? ☐ Pad ☐ Incontinence garments ☐ Bladder training garments ☐ Liner ☐ Other: _____		
87	Do you have constipation? ☐ Occasionally ☐ Often ☐ Always Methods used: _____		
88	Do you have liquid stools? ☐ Occasionally ☐ Often ☐ Always		
89	How often do you usually have a bowel movement? ☐ Every day or how many times per week: _____		

	COGNITIVE STATUS/BEHAVIOUR/COMMUNICATION	NO	YES
90	Do you have a vision problem? ☐ Glasses ☐ Contact lenses ☐ Cataract ☐ Other: _____		
91	Do you have difficulty hearing?		
92	Dou you have a hearing aid? ☐ Left ☐ Right		
	Do you use your hearing aid?		
93	Are you known to have: ☐ Memory problems ☐ Difficulty with understanding ☐ Depression ☐ Disorientation ☐ Behavioural disorder ☐ Delirium ☐ Dementia		
94	Do you have difficulty speaking?		
95	Have you recently suffered a traumatic brain injury?		
96	Do you have episodes when you are confused?		

	SLEEP	NO	YES
97	Do you have difficulty sleeping?		
98	Do you have difficulty falling asleep?		
99	How many hours of sleep do you usually get? Indicate your usual sleep schedule: _____		
100	Do you wake up often at night?		
101	Do you take naps?		
102	Do you take any medication to help you sleep? ☐ Every night ☐ A few nights per week Name of medication: _____		
103	Do you use other methods or habits that help you sleep (e.g. two pillows)? Specify: _____		

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	PLANNING YOUR RETURN HOME	NO	YES
104	Do you live with someone? If yes, with whom? ☐ Spouse ☐ Friend ☐ Child(ren) ☐ Other: _____		
	Who is the person designated to accompany you home when you are discharged? Name: _____ Tel. : _____ Indicate your relationship with this person: _____		
	How will you get home? ☐ Car ☐ Taxi ☐ Public transit		
	Where do you plan to go when you are discharged? ☐ Home ☐ Elsewhere, provide address: _____ Postal code: _____ Tel. : _____		
105	Is the person who lives with you able to help you when you get home? If no, do you have someone to help you? ☐ Day ☐ Evening ☐ Night		
	If necessary, is someone available to stay with you for the first 24 hours after you get home? Name: _____ Tel. : _____		
106	To help plan your return home, indicate what type of housing you will be living in: ☐ House ☐ Condominium ☐ Apartment ☐ Residence If a home: ☐ With care services ☐ With care services Name of the residence: _____ Tel. : _____ What floor do you live on? _____ Number of indoor stairs _____ Amount of outdoor stairs: _____ ☐ No elevator ☐ Elevator		
	Is your bedroom on the same floor as the bathroom?		
107	Do you regularly receive support to help you out at home? If yes, from whom? ☐ Family/friends ☐ Which organization: _____ ☐ CLSC – Name: _____ What kind of support or service? ☐ Bathing ☐ Eating ☐ Shopping (groceries, pharmacy, shops) ☐ Housework ☐ Other: _____		
108	Do you have other health problems that have not previously been mentioned in this form? _____ _____		

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HAVE YOU UNDERGONE ANY OF THE FOLLOWING TESTS IN THE PAST FIVE YEARS?				
Test	**No**	**Yes**	**If yes, where**	
Treadmill stress test				**If yes:** **<u>Please bring copies of your test results</u> at your appointment with the nurse.**
Echocardiography				
MIBI stress test (nuclear medicine)				
Coronarography				

HAVE YOU EVER UNDERGONE A Lungs function test **IN THE LAST 3 MONTHS?**	**No**	**Yes**	**If yes, where**	**If yes:** **<u>Please bring copies of your test results</u> at your appointment with the nurse.**

Don't forget:

- For your appointment with the nurse:
    - Bring a copy of the test results mentioned above
    - Bring your up-to-date drug profile from your community pharmacy
    - If you are diabetic, if possible, bring your capillary glycemia readings of the past three months
- If you are receiving care or treatments at the CLSC, please inform them of your upcoming surgery (provide the date if you already know it)

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