

PRE-ASSESSMENT QUESTIONNAIRE

Patient's Name (Last Name / First Name)			Referring Physician	
Patient's Address or Label			Physician's Address or Stamp	
Health Card No.	Gender (pls circle)		Physician Referring Number	
Version	Male Female			
Date of Birth <small>dd/mm/yyyy</small>	Daytime Phone	Evening Phone	Physician's Phone No.	Physician's Fax No.
1. Chief Complaint/s				
2. Allergies			3. Medications	
4. Surgical History (3 most recent surgeries)				
Date	Surgery			
5. Previous Anaesthetic Problems (operative complications)			Blood Transfusion / Haematology	
Y N			Y N	
<input type="checkbox"/> <input type="checkbox"/> Difficult Intubation <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> <input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> <input type="checkbox"/> Drug Reaction (describe) <input type="checkbox"/> <input type="checkbox"/> Other (describe)			<input type="checkbox"/> <input type="checkbox"/> HIV <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder (describe) <input type="checkbox"/> <input type="checkbox"/> Thrombotic Disorder (Dates) <input type="checkbox"/> DVT..... <input type="checkbox"/> PE <input type="checkbox"/> <input type="checkbox"/> Transfusion <input type="checkbox"/> <input type="checkbox"/> Hepatitis	

6. Pulmonary		Exercise Tolerance	
Y	N		
<input type="checkbox"/>	<input type="checkbox"/> COPD, Steroid Rx	<input type="checkbox"/> Chronic	<input type="checkbox"/> Intermittent
<input type="checkbox"/>	<input type="checkbox"/> Asthma, Steroid Rx	<input type="checkbox"/> Chronic	<input type="checkbox"/> Intermittent
<input type="checkbox"/>	<input type="checkbox"/> Restrictive Disease	<input type="checkbox"/> Cystic Fibrosis	
<input type="checkbox"/>	<input type="checkbox"/> Sleep Apnea		
<input type="checkbox"/>	<input type="checkbox"/> Smoking (heavy (Pck/Year, history)		
<input type="checkbox"/>	<input type="checkbox"/> Presently smoking		
<input type="checkbox"/>	<input type="checkbox"/> PFTs/ABG (include copies of most recent results)		
<input type="checkbox"/>	<input type="checkbox"/> Bedridden		<input type="checkbox"/> Assisted Movement
	<input type="checkbox"/> Limited (<1 FOS)	<input type="checkbox"/> Moderate (1-3 FOS)	
	<input type="checkbox"/> Active (>3 FOS)	<input type="checkbox"/> Regular Exercise	
	<input type="checkbox"/> Pneumonia		
	<input type="checkbox"/> Tuberculosis		
7. Cardiovascular		Cardiovascular Testing	
Y	N	Y	N
<input type="checkbox"/>	<input type="checkbox"/> Hypertension	<input type="checkbox"/>	<input type="checkbox"/> ECG
<input type="checkbox"/>	<input type="checkbox"/> Angina	Compared to previous testing	
<input type="checkbox"/>	<input type="checkbox"/> MI (Dates)	<input type="checkbox"/>	<input type="checkbox"/> Stress Test
<input type="checkbox"/>	<input type="checkbox"/> CABG (Dates).....	<input type="checkbox"/>	<input type="checkbox"/> Myocardial Perfusion
<input type="checkbox"/>	<input type="checkbox"/> Angioplasty (Dates)	<input type="checkbox"/>	<input type="checkbox"/> ECHO
<input type="checkbox"/>	<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/> Angiography
	<input type="checkbox"/> Symptomatic	<input type="checkbox"/>	<input type="checkbox"/> Holter
	<input type="checkbox"/> Previous Surgery	<input type="checkbox"/>	<input type="checkbox"/> MUGA
<input type="checkbox"/>	<input type="checkbox"/> CHF	<input type="checkbox"/>	<input type="checkbox"/> TEE
<input type="checkbox"/>	<input type="checkbox"/> Congestive Heart Defect (Describe).....	<input type="checkbox"/>	<input type="checkbox"/> Palpitations
	<input type="checkbox"/>	<input type="checkbox"/> Claudications
<input type="checkbox"/>	<input type="checkbox"/> Valvular Disease	<input type="checkbox"/>	<input type="checkbox"/> Varicose Veins
	<input type="checkbox"/> AS	<input type="checkbox"/>	<input type="checkbox"/> Edema
	<input type="checkbox"/> AI		
	<input type="checkbox"/> MS		
	<input type="checkbox"/> MR		
	<input type="checkbox"/> MVP		
	<input type="checkbox"/> Other		
	<input type="checkbox"/> If Repair (Date).....		
<input type="checkbox"/>	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/>	
	<input type="checkbox"/> SVT	<input type="checkbox"/>	
	<input type="checkbox"/> VT		
<input type="checkbox"/>	<input type="checkbox"/> Conduction Abnormality	<input type="checkbox"/>	
	<input type="checkbox"/> SSS	<input type="checkbox"/>	
	<input type="checkbox"/> CHB		
<input type="checkbox"/>	<input type="checkbox"/> Pacemaker: Type		
	Last Battery Check		
8. Metabolic and Other			
DM	TIA	ETOH	
CVA	SYNCOPE		
9. Medical History			
Y	N	Y	N
<input type="checkbox"/>	<input type="checkbox"/> Renal Disease	<input type="checkbox"/>	<input type="checkbox"/> Cancer
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/> Mental Illness

10. Social History				
Occupation		Smoking		Alcohol
Recreational Drugs				
11. Family History				
Y N		Y N		Y N
<input type="checkbox"/> <input type="checkbox"/> Heart Disease <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> Diabetes		<input type="checkbox"/> <input type="checkbox"/> Renal Disease <input type="checkbox"/> <input type="checkbox"/> Obesity <input type="checkbox"/> <input type="checkbox"/> Hypertension		<input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> Mental Illness <input type="checkbox"/> <input type="checkbox"/> Other
SYSTEMIC INQUIRY				
Head and Neck				
Y N		Y N		Y N
<input type="checkbox"/> <input type="checkbox"/> Eyes <input type="checkbox"/> <input type="checkbox"/> Ears <input type="checkbox"/> <input type="checkbox"/> Nose		<input type="checkbox"/> <input type="checkbox"/> Dental <input type="checkbox"/> <input type="checkbox"/> Throat <input type="checkbox"/> <input type="checkbox"/> Hoarseness		<input type="checkbox"/> <input type="checkbox"/> Masses <input type="checkbox"/> <input type="checkbox"/> Other
Neurological				
Y N		Y N		Y N
<input type="checkbox"/> <input type="checkbox"/> Headache <input type="checkbox"/> <input type="checkbox"/> Dizziness		<input type="checkbox"/> <input type="checkbox"/> Weakness <input type="checkbox"/> <input type="checkbox"/> Loss of Consciousness		<input type="checkbox"/> <input type="checkbox"/> Other
Gastrointestinal				
Y N		Y N		Y N
<input type="checkbox"/> <input type="checkbox"/> Nausea <input type="checkbox"/> <input type="checkbox"/> Vomiting <input type="checkbox"/> <input type="checkbox"/> Weight Change <input type="checkbox"/> <input type="checkbox"/> Dysphagia		<input type="checkbox"/> <input type="checkbox"/> Food Intolerance <input type="checkbox"/> <input type="checkbox"/> Abdominal <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> Constipation		<input type="checkbox"/> <input type="checkbox"/> Hematemesis <input type="checkbox"/> <input type="checkbox"/> Melena <input type="checkbox"/> <input type="checkbox"/> Jaundice <input type="checkbox"/> <input type="checkbox"/> Other
Musculoskeletal				
Y N		Y N		Y N
<input type="checkbox"/> <input type="checkbox"/> Arthritis		<input type="checkbox"/> <input type="checkbox"/> Back Pain		<input type="checkbox"/> <input type="checkbox"/> Other
Urine Test Results (as of date of assessment)				
	Pos.	Neg.	Creatinine: mg/dL	Signature:
BED			pH	
COC				
EDDP				
OXY				

PHYSICAL EXAMINATION

BP (L) (R)	Pulse	TEMP.	RR	Height (cm)	Weight (kg)	BMI***
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*** over 45 = not suitable for procedures at PES-Rudd Endoscopy Clinics

HEENT Carotid Bruit (L) (R)

Lungs

Cardiac

Abdomen

Extremities

Neuro

Assess Perioperative Risk:

Opinion

ASA Classification (please circle)***

1 2 3 4 5

*** Note: ASA 1 and 2 = acceptable for procedures at PES-Rudd Clinics
 ASA3 = decision of assessment specialist to recommend endoscopic procedure;
 ASA4 and 5 = not suitable for procedures at PES-Rudd Endoscopy Clinics.

Examining Physician's Name:

Signature:

Please also attach any relevant laboratory test results.

In the **Greater Toronto Area**, PLEASE FAX to **416-597-2912** or **905-607-0013**

In the **Ottawa Region**, PLEASE FAX to **613-216-1824**