Interior Health

SUMMERLAND Pre Surgical Screening Questionnaire
Page 1 of 2
PLEASE COMPLETE AND FAX BACK TO (250) 763-5131

FAMILY PRACTITIONER FAX: _____ **Date of birth** _____

Family Practitioner: _____ Surgeon: _____

Surgery Date: _____ Procedure: _____

Anesthesia: ☐ General Anesthesia ☐ IV Sedation ☐ Local

Anesthetic History (include dates & complications)

Date:		Date:	
Date:		Date:	

Pt/Family Hx of Anesthesia Problems?: ☐ None ☐ MH ☐ Pseudocholinesterase Deficiency

Details/Complications: _____

_____

SYSTEMS SUMMARY

Cardiac			☐ **None**
	Hypertension		Angioplasty/CABG/Stents
	Valve Problems		Arrhythmia/Pacemaker/Palpitations
	CAD/MI		CHF
Respiratory			☐ **None**
	Asthma (severity)		COPD
	OSA ☐ Diagnosed ☐ uses CPAP		
Exercise Tolerance			☐ **2 Flights Stairs OK**
Activity restricted by: ☐ Dyspnea ☐ Chest Pain ☐ Joint Pain ☐ Other:			
Neurological			☐ **None**
	TIA/CVA		Seizures/Head Injury
	Migraines		
	Other: Cerebral Palsy/Polio/Dystonia/Parkinson's/MS/ALS/Paraplegia/Myotonia		
Endocrine/Auto Immune/Other			☐ **None**
	Diabetes ☐ IDDM ☐ Type 2		RA/OA/Joint Injury
	Thyroid		GU/Renal/Continence Status
	GERD/Hiatus Hernia		Clotting/Anemia/DVT/PE/Transfusion Hx
	GI: Colitis/Crohn's		Hepatitis/HIV
	Chronic Pain		Organ Transplant
Other:			
Allergies: ☐ **Latex**			☐ **None**
Medications: ☐ **Prescription** ☐ **Herbal** ☐ **OTC**			☐ **None**

Drug	**Dose**	**Freq**	**Drug**	**Dose**	**Freq**

Stop taking all vitamins, herbals and supplements 1 week before surgery

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FAMILY PRACTITIONER FAX#

Substance Use:			☐ **None**
	Tobacco		Nicotine Replacement Therapy
	Alcohol		Recreational
Cognitive/Behavioral:			☐ **None**
	Memory Deficit/Vague Historian		Dementia
	Anxiety/Depression		Mentally Challenged
	Hx of Physical Attack on Others		Other: *eg: ADHD, autism*

Physical Examination				
BP	Pulse	**HT *(required)***	**WT *(required)***	**BMI *(required)***

Head & Neck:	CNS:
Normal mouth opening: ☐ Yes ☐ No	
Heart:	Lungs:
Neurological:	Other:
Lab Work: please attach any relevant investigations	

Physician Signature

Date Completed

Print Physician Name

Physician Clinic Phone number

Pre-Surgical Screening Clinic and/or Anesthetist Use:

To be Investigated Further: ☐ **Yes** ☐ **No**

APPROVED FOR SURGERY:

Anesthetist Signature

Date

Pre–Operative Orders: _____