☐ Mount Saint Joseph Hospital
☐ St. Paul's Hospital

# HEALTH HISTORY – PATIENT QUESTIONNAIRE

Patient Name: ____________________________________________

☐ Male ☐ Female Birth Date: ____________________________

Height: ______________________ Weight: ___________________

Phone Number: ____________________________________ Alternative Phone Number: ________________________________

## Do you have or have you ever had any of the following? (tick all that apply)

☐ I have had **problems** with local freezing (anesthetic) or general anesthetic (specify) _______________________________
☐ A blood relative of mine has had **problems** with local freezing (anesthetic) or general anesthetic (specify) __________________
☐ I have trouble or difficulty opening my mouth or moving my neck
☐ I have been a smoker for _____ years How many cigarettes a day? ______
☐ I drink alcohol How much do you drink in a week? _____
☐ I use street drugs Types: ____________________________________________
☐ I am pregnant or could be pregnant Due Date: ______________ or Date of last menstrual period: ___________________
☐ I have general body pain ☐ I have ongoing pain Where?_________________________________________
☐ I am HIV positive

## Tell Us About Your Medical History (tick all that apply)

### HEART

☐ Chest Pain or Angina How often:_____ Last date:________
☐ I get chest pain, pressure, or tightness when I climb 2 flights of stairs or less
☐ Heart Attack(s) Date of most recent: ___________ ☐ Abnormal ECG/Heart Tracing
☐ High Blood Pressure for _______ years ☐ Congestive Heart Failure for _______ years
☐ Irregular Heart Beat, Palpitations ☐ Automatic Implantable Cardioverter Defibrillator (AICD) Date_________
☐ Heart Murmur, Valve Problems, Leaky Valve ☐ Pacemaker Date: ________
☐ Heart Surgery or Bypass Surgery Date:_________ ☐ Angioplasty Date:________________

### BREATHING

☐ I have been admitted to the hospital within the last 6 months with shortness of breath
☐ I have trouble breathing or become short of breath when I climb 2 flights of stairs or less
☐ I get short of breath walking 2 block or less
☐ I have Asthma ☐ I use puffers regularly and/or frequently How often? ___
☐ I have gone to the emergency department because of my asthma Date: ________
☐ I have Chronic Obstructive Pulmonary Disease (emphysema or chronic bronchitis) ☐ I use home oxygen
☐ I have Sleep Apnea (stop breathing while you're sleeping) ☐ I use a CPAP machine ☐ I use a BIPAP machine
☐ Pneumonia in the past Last treated: ________________ ☐ Tuberculosis Date treated: ___________________________

### CIRCULATION

☐ I have a lot of bruising or bleeding that does NOT seem to have a cause
☐ I have a bleeding or clotting disorder ☐ I have hemophilia
☐ Blood clots in lungs (pulmonary embolism) ☐ Blood clots in legs (DVT)

☐ I take blood thinners:
- ☐ Aspirin
- ☐ Warfarin or Coumadin
- ☐ Plavix
- ☐ Other:______________

### PHYSICAL ACTIVITY / FUNCTION/ SOCIAL SUPPORT

☐ I go for a walk_____ times per week ☐ I use walker or cane ☐ I have fallen in last 3 months
☐ I need help with eating, bathing ,dressing, toileting and walking ☐ My family helps me with cleaning, driving, shopping, cooking
☐ I receive community home support ☐ My memory is not as good as before ☐ I need help with taking my medication

### DIGESTIVE SYSTEM

☐ In the last 6 months I have lost weight without trying: ☐ 2 to 13 lb ☐ 14 to 23 lb ☐ 24 to 33 lb ☐ more than 34 lb ☐ unsure
☐ I have been eating poorly because of a decreased appetite or chewing/swallowing difficulties
☐ Heart burn, hiatus hernia, gastric reflux

### LIVER

☐ Hepatitis or Jaundice (yellowing in the skin) ☐ Cirrhosis

### ENDOCRINE

☐ Thyroid Problems: ____________________________________________
☐ Diabetes ☐ Taking insulin ☐ Taking pills ☐ Diet controlled

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# HEALTH HISTORY – PATIENT QUESTIONNAIRE

**KIDNEYS**

☐ Bladder problems ☐ Prostate problems ☐ Kidney problems ☐ Kidney failure
☐ On Hemodialysis ☐ On Peritoneal dialysis ☐ Kidney transplant Date: ____________________

**MUSCLES / JOINTS / NERVES**

☐ History of weakness, paralysis, numbness, black outs (specify) ____________________
☐ Arthritis ☐ Osteoarthritis ☐ Rheumatoid arthritis
☐ Stroke Date: ____________________ ☐ Mini-stroke (TIA) Date: ____________________
☐ Seizures/Epilepsy: ____________________ ☐ Multiple Sclerosis ☐ Myasthenia Gravis ☐ Muscular Dystrophy

| Have you ever had a: | Where was the test done? | When? |
|---|---|---|
| ☐ Exercise stress test (treadmill) | ____________________ | Date: ____________ |
| ☐ Nuclear medicine heart scan (MIBI) test | ____________________ | Date: ____________ |
| ☐ Heart catheterization (angiogram) | ____________________ | Date: ____________ |
| ☐ Heart echo test (ultrasound of the heart) | ____________________ | Date: ____________ |
| ☐ Holter monitor (worn a heart monitor for 24 hours) | ____________________ | Date: ____________ |
| ☐ Lung function test (Pulmonary function test) | ____________________ | Date: ____________ |

| Have you ever been seen by a: | Name of Doctor? | When? |
|---|---|---|
| ☐ Heart Specialist (Cardiologist) | Dr. ____________________ | Date: ____________ |
| ☐ Lung Specialist (Respirologist) | Dr. ____________________ | Date: ____________ |
| ☐ Nerve Specialist (Neurologist) | Dr. ____________________ | Date: ____________ |
| ☐ Blood Specialist (Hematolgoist) | Dr. ____________________ | Date: ____________ |
| ☐ Other Specialist: ____________ | Dr. ____________________ | Date: ____________ |
| ☐ Other Specialist: ____________ | Dr. ____________________ | Date: ____________ |

**List any surgeries or minor procedures you have had in the past using anesthesia**

| Operation/Minor procedure | Where was it done? | When? |
|---|---|---|
| ____________________ | ____________________ | Date: ____________ |
| ____________________ | ____________________ | Date: ____________ |
| ____________________ | ____________________ | Date: ____________ |

**Do you have any allergies?** (for example: medicine, food, latex, tape, bandages)

| I am allergic to: | My reaction: | I am allergic to: | My reaction: |
|---|---|---|---|
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |

**List all of the medicines that you take** (including herbal, vitamins, and non-prescription drugs)

| | | | |
|---|---|---|---|
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |

**Tell us about any other serious illnesses or limitations that have not been identified already?**

**Questionnaire completed by:**

Printed name: ______________________________ Date: ____________________

If you are not the patient, what is your relationship to the patient? ____________________

| For Pre-Assessment Clinic use only | | |
|---|---|---|
| ☐ Reviewed by PAC RN | Signature: ____________________ | Date: ____________ |
| ☐ Reviewed by Anesthesiologist | Signature: ____________________ | Date: ____________ |

# PRE-ADMISSION INFORMATION

**Please complete and return promptly**

Date of form completion: ______________________________

## ADMISSION INFORMATION

**SITE:**

☐ **Holy Family Hospital**
Admitting Department
7801 Argyle Street, Vancouver, BC V5P 3L6

☐ **Mount Saint Joseph Hospital**
Admitting Department
3080 Prince Edward Street, Vancouver, BC V5T 3N4

☐ **St. Paul's Hospital**
Pre-Admission Clinic
1081 Burrard Street, Vancouver, BC V6Z 1Y6

**Type of Admission:**

☐ Inpatient
☐ Surgical Day Care
☐ Maternity
Expected date of delivery: ______________________________

**Expected date of admission / visit:** ______________________________

Have you ever been a patient at Providence Health Care? ☐ Yes ☐ No

## PERSONAL INFORMATION

**Patient's Legal Name:** ______________________________
Last Name First Name Middle Name Other names used

**Sex:** ☐ Male ☐ Female **Date of Birth:** dd/mmm/yyyy: ______________________________

**Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Common-law ☐ Widow ☐ Companion live-in

If you would like your faith or denomination noted on your record, please indicate it here: ______________________________

If you prefer communication in a language other than English, please indicate it here: ______________________________

**Personal Health Number:** (CareCard number) ______________________________

**Family Physician or clinic you attend:** ______________________________

Admitting Physician / Surgeon / Obstetrician / Midwife: ______________________________

## ACCIDENT

**Is this visit due to an accident?** ☐ No ☐ Yes If yes, date of accident: ______________________________

Time of accident: ______________________________ Place of accident: ______________________________

Details of accident: ______________________________

## ADDRESS

**Patient's Permanent Address:** ______________________________
Street

______________________________
City Province Postal Code Country

How long have you lived at the above address? ______________________________

**Phone:** Cellular: ______________________________ Home: ______________________________

**Email address:** ______________________________
(Email and cellular phone texting may be used for follow-up by PHC)

**Previous Address:** ______________________________
(If less than six months at current address) Street

______________________________
City Province Postal Code Country

**PLEASE COMPLETE THE BACK OF THIS FORM**

Providence
HEALTH CARE

# PRE-ADMISSION INFORMATION

**Please complete and return promptly**

## PERSONS TO CONTACT

**Legal Next-of-Kin:** ______________________ **Relationship:** ______________________
Name (spouse if married)

**Address of Next-of-Kin:** ______________________
(If different than patient) Street

______________________
City Province Postal Code Country

Telephone number of Next-of-Kin: (if different from patient) Cellular: ______________________

Home: ______________________

**Emergency Contact:** (if different from Next-of-Kin) ______________________

**Relationship:** ______________________ Phone: ______________________

**Address of emergency contact:** ______________________
(If different than patient) Street

______________________
City Province Postal Code Country

## RESIDENT / CITIZEN / IMMIGRANT / VISA / REFUGEE

- ☐ **BC Resident**
- ☐ **Canadian Citizen**
- ☐ **Landed Immigrant**
- ☐ **Visa**
- ☐ **Refugee**

If less than 3 months, date arrived in BC: ______________________

If landed immigrant or refugee, without a BC CareCard, **OR** on a visa, please provide a photocopy of your immigration or visa paper.

If refugee, please provide copies of both refugee documents.

## INSURANCE INFORMATION

If **WorkSafeBC** (WSBC), please provide WSBC Claim Number: ______________________

If **ICBC** please provide ICBC Claim Number: ______________________

ICBC Adjuster's name: ______________________

Office: ______________________

## EXTENDED HEALTH COVERAGE / ACCOMMODATION PREFERENCE

**Accommodation Preference:**

☐ Standard ward - ________________No charge.

☐ Private room / Private bath $ 195.00 ☐ Semi-private room $ 165.00

*Private and semi-private rooms are subject to availability.*
*A deposit may be required for private and semi-private room requests. Prices are subject to change.*

*Signature:* ______________________