Kamloops Surgical Centre
200-741 Sahali Terrace
Kamloops, BC V2C 6X7
Phone: 250-314-0076 Fax:
250-314-1196

Patient Label

Pre-Operative Questionnaire

Name:______________________________

Signature:__________________________

Date:______________________________

Height:______________ Weight:______________

Allergies: ______________________

Patient Phone Number: ______________

Next of Kin name/phone #: ______________

Escort/Ride Name/phone #: ______________

Medication: List prescription, over the counter, herbal, naturopathic medicines, recreational drugs or vitamins that you regularly use:

____

____

____

Do you or have you ever had (Describe)	Yes	No	Don't Know
Heart attack or angina? If yes answer the following:			
How often do you have angina? What relieves it?			
Have you ever fainted?			
Other heart problems (such as rhythm problems)			
Have you ever had a blood clot? If yes, explain			
Asthma or lung disease? Do you use home O2?			
Epilepsy, stroke or nervous system disease?			

Do you or have you ever had (Describe)	Yes	No	Don't Know
High blood pressure?			
Are you on blood thinners or antiplatelets?			
Do you use puffers?			
Do you ever experience shortness of breath at rest?			
Do you experience shortness of breath while laying flat?			
Can you climb a flight of stairs or walk a block on level ground?			
Do you prop yourself up at night to sleep?			
Have you been tested for sleep apnea (interruption of breathing during sleep) If **yes**, Answer next 2 Questions			
Was a CPAP Machine recommended?			
Do you use a CPAP machine?			
Liver disease, hepatitis, or HIV?			
Kidney disease?			
Diabetes: Type 1 or Type 2?			
Thyroid disease? Hyper or Hypo active? Cancer?			
Heartburn, ulcer, or hiatus hernia?			
Diagnosed with antibiotic resistant organism? (MRSA, VRE, ESBL)			
Chronic pain?			
Can you open your mouth at least 2 finger widths?			
Problems with surgeries/anesthesia? If **yes**, explain			
Family problems with anaesthesia? If **yes**, explain			
Other major health problems (please list)			
Do you experience anxiety, depression or other psychological illness?			
Special needs (example: autism - please specify)			
Do you drink more than two alcoholic beverages per day?			
Do you smoke/use (tobacco, marijuana or other)			
If yes, what, how much and last use?			

KSC
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OBSTRUCTIVE SLEEP APNEA (OSA) SCREENING QUESTIONNAIRE

1. **Have you been tested for or diagnosed with sleep apnea?** ☐ Yes ☐ No
   - If so, when? ______
   - Obtain results from GP and/or EMR and attach to either the Patient Questionnaire or to this form.
   - ______ **AHI Score** (Apnea Hypopnea Index)

2. **Do you use CPAP, BIPAP or a dental appliance when sleeping?** ☐ Yes ☐ No

3. **OSA Questionnaire**
   ("STOP" : S – Snore, T – Tired, O – Observed, P – Pressure)

Do you snore louder then talking or loud enough to be heard through closed doors?	☐ Yes	☐ No
Do you often feel tired, fatigued, or sleepy during the daytime?	☐ Yes	☐ No
Has anyone noted that you stop breathing during your sleep?	☐ Yes	☐ No
Do you have or are you being treated for high blood pressure?	☐ Yes	☐ No

☐ **Two or more Yes answers**

4. **Patients with excess adipose tissue in the neck:**
   Neck circumference measurement: ______ ☐ unable to obtain
   Women: Neck circumference >16 inch / 41 cm? ☐ **Yes**
   Men: Neck circumference > 17 inch / 43 cm? ☐ **Yes**

5. **Patients with a body mass index (BMI) > 35 kg/m² : BMI: ______** ☐ **Yes**

6. **Additional risk factors of age or gender:**
   Age > 50 years old? ☐ **Yes**
   Male? ☐ **Yes**

If any: Yes: box is checked above, the patient is at risk for OSA and a diagnostic workup is recommended.

Completed by: (Print Name) ______ Initials: ______ Date: ______

Anesthesia only to complete:

☐ No testing required

☐ Overnight Oximetry Date: ______

☐ Polysomnogram Date: ______

OSA Plan:

☐ Requires OSA Post– Op Monitoring

☐ 1st on operating slate ☐ Yes ☐ No

☐ Not suitable for surgery at KSC

Date: ______ Physician: ______