Victoria Surgery SINCE 1966

Self-reported

Patient Survey

3rd floor - 715 Finlayson Street T: 250-595-1553
Victoria BC V8T 2T4 F: 250-595-1518
e-mail: patientcare@victoriasurgery.com

Please complete and return this form to Victoria Surgery ASAP

Your name: _____

Allergies:

Please list your allergies and describe the allergic reaction: _____

_____

Latex allergy enquiry:

Do you have a personal or family history of allergic reactions?	yes	no
Have you ever had respiratory distress, rapid heart rate, swelling or anaphylactic episode?	yes	no
If yes explain: _____		
Have you ever had an undiagnosed rash for longer than one week?	yes	no
Have you every been diagnosed with a latex allergy by a physician?	yes	no
Have you ever had swelling, itching, hives, redness, irritation or wheezing:		
• After contact with latex or rubber products?	yes	no
• After contact with a balloon?	yes	no
• After any exam or procedure?	yes	no
• After using a diaphragm or condom?	yes	no
• After wearing rubber gloves for one hour?	yes	no
• After wearing elastic or stretch clothing?	yes	no
Are you allergic to bananas, papaya, avocados, kiwi, tomatoes, chestnuts, poinsettia or passionfruit?	yes	no
Have you undergone multiple medical or surgical procedures?	yes	no
Are you a health care worker?	yes	no

Medications:

Please list your medications: _____

_____

Are you taking Aspirin regularly? If yes, what dose? 81mg 325mg	yes	no
Are you taking any anticoagulants (blood thinners)? If yes, which? _____	yes	no
The physician who is managing your blood thinning medication: _____		

Medical conditions: Please circle if you currently have, or ever have had any of the following:

If you answer "yes" to any of the following please include as much detail as possible on a separate page.

Gastro-esophageal reflux	yes	no	Concussion / Traumatic Brain Injury	yes	no
Neuropathy	yes	no	Liver disease, Jaundice, Hepatitis	yes	no
Rheumatological disorder	yes	no	Malignant Hyperthermia	yes	no

Obstructive sleep apnea: OSA

Do you snore loudly (loud enough to be heard through closed doors)?	yes	no	1
Do you often feel tired, fatigued, or sleepy during the daytime?	yes	no	1
Has anyone observed you stop breathing, choke, or gasp while asleep?	yes	no	1
Are you being treated for high blood pressure?	yes	no	1
Is your neck size greater than 43cm (male) or 41cm (female)?	yes	no	1

(BMI > 35 = 1 • Age > 50? = 1 •. Gender = Male? = 1

Total OSA score ____

Venous thromboembolism:

Have you ever had:			VTE				VTE
Deep venous thrombosis	yes	no	3	Spontaneous abortion	yes	no	1
Swollen legs	yes	no	1	Congestive heart failure	yes	no	1
Varicose veins	yes	no	1	Inflammatory bowel disease	yes	no	1
Cancer (list type) _____	yes	no	2				

Have you had a TIA (transient ischemic attack) or stroke within the past month?	yes	no	5
Have you recently had a heart attack (myocardial infarction)?	yes	no	1
Have you had a serious infection within the past month?	yes	no	1
Have you had pneumonia or serious lung disease within the past month?	yes	no	1
Are you recently postpartum?	yes	no	1
Do you take oral contraceptives?	yes	no	1
Have you been diagnosed with Factor V Leiden?	yes	no	3

BMI >25 = 1 • age 41 - 60 = 1 61 - 74 = 2 > 75 = 3 • minor surgery = 1 • major surgery = 2 • arthroscopic surgery = 2

laparoscopic surgery >45 mins = 2 • arthroplasty = 5 • hip, pelvis or leg fracture = 5 • congenital or acquired thrombophilia = 3

Total VTE score ____

Antibiotic resistant organisms:

Have you been admitted to a hospital for more than 48 hours in the past year?	yes	no
Have you received chemotherapy or dialysis in the past year?	yes	no
In the last year have you or a member of your household had a difficult to treat skin infection?	yes	no
If yes, how was it resolved? _____		
Have you or a member of your household been told that you carry antibiotic resistant organism?	yes	no
Have you ever been treated for HIV / AIDS, or hepatitis B or C?	yes	no
Have you used any street drugs other than marijuana in the past month?	yes	no
Have you had a medical procedure outside of Canada in the past 90 days?	yes	no
Do you smoke? If yes, for how long? _____	yes	no
Have you or a blood relative experienced any serious complication from a general anesthetic?	yes	no
Do you experience nausea from general anesthetic?	yes	no
Are there any pain medications that that do not work well for you or cause side effects?	yes	no
Is there any significant chance you may be pregnant?	yes	no

Previous surgical history:

Procedure: _____	When: _____
Procedure: _____	When: _____
Procedure: _____	When: _____

2021-07