



Self-reported

Patient Survey

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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 40 cm (16 in)?		yes	no			1	
(BMI > 35 = 1 • Age > 50? = 1 • Gender = Male? = 1							
Venous thromboembolism:				Total OSA score _____			
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 _____							
Seq. compression for procedure length > 1 hr √ • if VTE score > 5 consider LMWH • Reviewed by physician : _____							
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: _____			