PATIENT PRE-PROCEDURE QUESTIONNAIRE HISTORY AND ASSESSMENT

Patient identification

Please answer "yes" or "no" to the following questions

MEDICAL HISTORY	YES	NO	NURSE	MEDICAL HISTORY	YES	NO	NURSE
Gastrointestinal Do you have any problems/diseases of the stomach or bowel?				Endocrine Do you have any liver problems (hepatitis, jaundice?)			
Cardiovascular Have you ever had a heart attack?				Do you have diabetes/high blood sugar?			
Do you have any heart palpitations, dysrhythmias, or irregularities?				Neurological Do you have numbness, tingling, or weakness in your arms or legs?			
Do you have a heart murmur or problems with valves in your heart?				Have you ever had blackouts or fainting spells?			
Do you have high blood pressure?				Have you ever had a stroke or seizure?			
Do you smoke? (If yes, nurse to complete the 4 As) __ Advise patient to quit smoking __ Assess readiness to quit __ Assist: brief education on cessation & pharmacotherapy __ Arrange: refer to: self help material, smokers' helpline, pharmacist, primary care giver, community resources				Bleeding Were you advised to stop taking any medications (i.e. Coumadin, aspirin, anti-inflammatory medications) prior to this procedure?			
Genito-urinary Do you have kidney or urinary problems?				Falls Risk (for Nurse use) Level 1 2 Interventions in place			
Could you possibly be pregnant?				Musculo-skeletal Do you require assistance or devices to mobilize?			
Respiratory Do you have asthma, bronchitis, tuberculosis (TB), chronic obstructive pulmonary disease (COPD) or emphysema?				Other Do you wear a hearing aid? Do you have dentures/partials? Do you wear glasses or contact lenses?			
Alcohol Intake Do you drink alcohol?				Communication Do you need an interpreter?			
If yes, how many drinks per day?							

SURGICAL HISTORY – please list any previous operations below

Do you have any objections to any of the following students observing your procedure?

Medical Yes No Paramedical (nursing, physio, OT, etc.) Yes No High school co-op Yes No

Print and sign (patient and/or family member) Date

Reviewed by (signature of nurse) Date

BRANT COMMUNITY HEALTHCARE SYSTEM Brantford General Hospital Site **BEST POSSIBLE MEDICATION HISTORY (BPMH) SHEET** ALLERGIES: HT:__________________ WT:__________________	(For clinic use only) *Patient Identification*
Source of Medication Information check all that apply (for clinic use only) __ Patient __ Family Member __ Medication Vials __ Ontario Drug Benefit Medication List __ MAR from other facility __ Community Pharmacy Name: Phone: __ Other:	**Drug insurance:** **(For clinic use only)** __ Indian Affairs __ Ontario Disability Support Program __ Ontario Works __ Seniors __ Third Party __ Trillium __ NONE

MEDICATION HISTORY: List all prescription and non-prescription medications (including eye drops, inhalers, insulin, creams, patches, vitamins and herbal medications) taken regularly and PRN

Medication name __ No medications	**Dose**	**Route**	**When do you take them?**	**Comments**
Example: *Metformin*	*500 mg*	*By mouth*	*Every morning and evening*	

BPMH Reviewed By: (Signature): ___________________________ Date (dd/mm/yyyy) and time: ___________________