whitehorse general hospital
hôpital général de whitehorse

WGH Preoperative Clinic
Patient Self-Assessment

MUST BE FAXED to 393-8951 with ALL surgical orders

Last Name	**Height :**
First name	**Weight :**
Middle Initial	
Date of birth (dd/mm/yy)	

Have you had/ do you have?	Yes	No	Have you had/ do you have?	Yes	No
Chest pain			Heartburn/ hiatus hernia (circle)		
Heart attack			Stomach ulcers		
Heart murmur			Liver disease		
Stroke			Kidney disease		
High blood pressure			Diabetes		
Irregular pulse			Thyroid disease		
Anemia			Blood clotting problem		
Asthma/ bronchitis/ emphysema (circle)			Seizures		
Shortness of breath with normal activity			Paralysis / weakness		
Snore			Rheumatoid arthritis		
HIV, hepatitis B, hepatitis C (circle)			Osteoarthritis, wear and tear arthritis		
Other Medical Conditions*:*					

Do you / Did you?	Yes	No	If quit, when
Smoke tobacco			
Consume alcohol			
Use street drugs			

Have you had/ do you have?	Yes	No	Don't know
Any problems with anesthesia			
Any close relatives with problems with anesthesia			
Obstructive sleep apnea, stop breathing when sleeping on your back, use CPAP			

Previous surgeries

PLEASE COMPLETE BOTH SIDES of FORM

Revised : March 2020

Last Name		**Complete again please**
First name		
Middle Initial		
Date of birth (dd/mm/yy)		

Medication you take regularly, including vitamins, herbal and dietary supplements.
Bring printed copy from your Pharmacy

Drug	Dose & Strength	When you take it

Describe any serious reaction or allergies to drugs, foods, etc.		
Allergies	Yes	No
Do you have a Latex Allergy?	Yes	No

Y	N	For Infection Control
		Direct transfer from or admission in a facility outside Canada during the previous 6-12 months?
		Transferred directly from or been in hospital for more than 24 hours (including Emergency Admissions) during the previous 6 – 12 months within Canada?
		Have you previously had an Antibiotic Resistant Infection / "Superbug" (MRSA – Methicillin Resistant Staphylococcus Aureus) or suspected of having one in previous 6-12 months?
		Have you recently (within the last year) been incarcerated, lived in a shelter, been homeless (no fixed address) or used street drugs (IV Drug use)?
		Do any of your household members have a history (within the past 6 months) of non-healing skin infections such as cellulitis, wounds, abscess or boils?
		Do any of your household members have a history (within the past 6 months) of Antibiotic Resistant Infection / "Superbug" (MRSA - Methicillin Resistant Staphylococcus Aureus)?
		Do you reside in a long term care setting, like Copper Ridge Place, Macaulay Lodge, MacDonald Lodge or another long term care facility? Have you had a respite stay in a long term care facility in last 12 months?
		Have you received dialysis or chemotherapy within the last year?

Post-Surgery: Patients undergoing general anesthesia for day surgery are required to have a responsible person with them for 24 hours post-surgery. Please indicate the person and relation who will stay with you for 24 hours after surgery. Name _____Relation_____

Signature of person completing the information | Relation to patient (if applicable) | Date (dd/mm/yy)

Emergency, contact: _____ Phone Number: _____

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