KAMLOOPS SURGICAL CENTRE

Pre-Operative Questionnaire

KAMLOOPS Surgical Centre LTD

Name:_____

Signature:_____

Date:_____

Height:_____ Weight:_____

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

Allergies: _____

Next of Kin/phone number: _____

Do you or have you ever had (Describe)	Yes	No	Don't Know
High blood pressure			
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)			
Asthma or lung disease			
Do you use puffers?			
Do you ever experience shortness of breath?			
Can you climb a flight of stairs or walk a block on level ground?			
Do you exercise?			
Liver disease, hepatitis, or HIV			
Kidney disease			
Diabetes: Type 1 or Type 2			
Thyroid disease			
Epilepsy, stroke or nervous system disease			
Heartburn, ulcer, or hiatus hernia			
Have you ever had a blood clot? If yes, explain			
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)			
Mental health disorder/Anxiety			
Special needs (example: autism - please specify)			
Do you drink more than two alcoholic beverages per day?			
Do you smoke? If so, how much?			
If you smoked in the past, when did you quit?			

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

Stop Bang Score - KSC Office only to complete. Age: Gender: BMI: Total Score: /8

OBSTRUCTIVE SLEEP APNEA (OSA) SCREENING QUESTIONNAIRE

KAMLOOPS Surgical Centre LTD

Patient Name:

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.

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/m^2 : 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. Patients with one or more risk factors in question 6 should receive consideration for OSA testing if they have values close to significance in questions 3, 4, or 5.

KSC Office only to complete:

☐ No testing required

☐ Overnight Oximetry Date: _____

☐ Polysomnogram Date: _____

Date: _____ Nurses Signature: _____

OSA Plan:

☐ Requires OSA Post– Op Monitoring

☐ 1st on operating slate ☐ Yes ☐ No

☐ Not suitable for surgery at KSC

Date: _____ Physician: _____