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General Surgery and Endoscopy
Canmore General Hospital
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PLEASE ATTACH PATIENT LABEL HERE

To Be Completed By Patient Or Guardian

1. Cardiovascular	YES	NO
Chest pain or angina	☐	☐
History of Heart Attack(s)	☐	☐
(Congestive)Heart Failure	☐	☐
Heart Murmur	☐	☐
If so, do you take antibiotics before dental work?	☐	☐
Stroke	☐	☐
High or Low Blood Pressure	☐	☐
Irregular Pulse/Palpitations	☐	☐
Do you take pills to thin blood	☐	☐
Do you take aspirin, anti-inflammatory drugs	☐	☐

Please list _____

2. Renal

Kidney problems/failure	☐	☐
Difficulty urinating	☐	☐

3. Respiratory	YES	NO
Asthma/Bronchitis	☐	☐
Emphysema	☐	☐
Shortness of breath with normal activity for age	☐	☐
Productive Cough	☐	☐
Sleep Apnea	☐	☐
Smoker (Quit _____)	☐	☐

4. Gastro Intestinal

Heartburn/Hiatal Hernia	☐	☐
Stomach Ulcers	☐	☐
History Hepatitis	☐	☐
Rectal Bleeding	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
History of Cirrhosis	☐	☐

5. Other	YES	NO
Diabetes	☐	☐
If yes, do you take Insulin	☐	☐
Thyroid Problems	☐	☐
Anemia (low iron)	☐	☐
Bleeding Disorders	☐	☐
Joint Problems	☐	☐
Rheumatoid Arthritis	☐	☐
HIV Infection or other _____	☐	☐
Tumours/Malignancy	☐	☐
Possibility of Pregnancy	☐	☐
Breast Feeding	☐	☐

6. Do you drink more than one alcoholic drink per day	☐	☐
Do you use recreational drugs	☐	☐

7. Have you had previous surgery and anaesthesia, if so list procedure and year? **Yes No**

8. Do you have any ALLERGIES or sensitivities? Please list: **Yes No**

9. Do you take any **prescription, non-prescription medications?** Our office does not accept medication lists. **Yes No**
****If too many to list, please handwrite your current medications and attach to this questionnaire with the date and signature.**

10. Do you snore loudly? (Loud enough to be heard through closed doors?) **Yes No**
Do you often feel tired, fatigued or sleepy during the day even after a "good" night sleep **Yes No**
Has anyone observed you stop breathing or choking/gasping during your sleep? **Yes No**
Do you have or are being treated for high blood pressure? **Yes No**
Neck Size greater than 40cm around? **Yes No**
Body Mass Index – Higher than 35? **Yes No Unsure** Older than 50 years? **Yes No** Male? **Yes No**
Height: **Weight:** **lbs/kg**

11. Do you have any blood relatives that have suffered from **colon or bowel cancer?** i.e. mother, father, brother, sister **Yes No**
Please list: _____ Age of diagnosis: _____
_____ _____

12. Have you had a colonoscopy **YES NO** **If yes**, did you have polyps removed **YES NO**
If yes; please list the year, the doctor that performed the test, or the hospital

Date: **Print Name:** **Signature:**

Alberta Health Services