
Identification questionnaire

Please complete this questionnaire in order to facilitate coordination and organization of your care with other healthcare providers.

Identification

Legal name:

Legal first name:

Chosen last name:

Chosen first name:

Date of birth:

Pronoun: He ☐ She ☐ They ☐ Other:

mm/dd/yyyy

Language of communication: French ☐ English ☐Need a translator: Yes ☐ No ☐Other ☐ (please specify: _____)

Health insurance number:

Issuing province:

Full name registered on the card:

Expiration date:

mm/yyyy

Contact information

Address:

Civic no

street

App.

City:

Province:

Postal code:

Country:

Office phone number:

Home phone number:

Cell phone number:

Email address:

Contact in case of emergency

Person's name:

Phone number:

Connection:

E-mail:

Contact details of your healthcare providers

Name of your attending physician:

Name and address of the clinic:

Phone number:

Extension:

Name of your prescribers of hormone therapy:

Name and address of the clinic:

Phone number:

Extension:

Name of another stakeholder, if applicable:

Name and address of the clinic:

Phone number:

Extension:

Issuer of the first letter of recommendation: professional title:

Name:

Phone number:

Issuer of the secondary recommendation letter if applicable: professional title:

Name:

Phone number:

Name	
First name	
Date of birth	Age
H.I.N.	Exp.

PREOPERATIVE QUESTIONNAIRE

Expected surgery(ies):								
Age:	Weight:	pd/kg	Height:	pi/m	BMI:	kg/m ²	B.P...:	Pulse:
Denture(s), bridges(s), crown(s):			Hearing aid(s):			Contact lenses:		
Yes ☐ No ☐			Yes ☐ No ☐			Yes ☐ No ☐		
Known treated medical condition(s):					Previous surgery(ies)			
Known untreated medical condition (s):								

List of medication :

1. _____
2. _____
3. _____
4. _____
5. _____

List of natural products :

1. _____
2. _____
3. _____
4. _____
5. _____

Are you taking:

Anticoagulants?

Yes

☐

No

☐

If so, which ones: _____

Aspirin?

Yes

☐

No

☐

Have you ever had anesthesia :

General?

Yes ☐

No ☐

Regional?

Yes ☐

No ☐

Local?

Yes ☐

No ☐

Previous history of nausea and vomiting

postoperatively? Yes ☐ No ☐

During anesthesia, did you, or a member of your family, ever had any complication?

Yes ☐ No ☐

If so, which ones : _____

PREOPERATIVE QUESTIONNAIRE

Do you have allergies to:

Specify

Medication: Yes ☐ No ☐ _____
 Latex: Yes ☐ No ☐ _____
 Food: Yes ☐ No ☐ _____

Do you have food

intolerance? Specify: _____

Lifestyle habits :

Tobacco: Yes ☐ No ☐ Consumption/daily: _____ Vegetarian Yes ☐ No ☐

If stopped, since when: _____ Vegan Yes ☐ No ☐

Alcohol: Yes ☐ No ☐ Consumption/daily: _____

Drug(s): Yes ☐ No ☐ Consommation/frequency: _____

Could you possibly be pregnant? Yes ☐ No ☐

In the past 4 weeks, have you had a cold or the flu? Yes ☐ No ☐

Have you taken cortisone orally In the past 12 months ? Yes ☐ No ☐

Have you ever received chemotherapy or radiotherapy treatments ? Yes ☐ No ☐

In the current year, have you been hospitalized for more than 24 hours ? Yes ☐ No ☐

If so, for which reason (s): _____

At which hospital ? _____

Do you have heart related problems ?

Pain (angina) : Yes ☐ No ☐
 Shortness of breath : Yes ☐ No ☐
 Palpitations / arrhythmia Yes ☐ No ☐
 Hypertension (blood pressure) : Yes ☐ No ☐
 Myocardial infarction (heart attack) : Yes ☐ No ☐
 Heart failure : Yes ☐ No ☐
 Valvular disorder {heart murmur} : Yes ☐ No ☐

Do you have a pacemaker ? Yes ☐ No ☐

If so, what kind ? Permanent pacemaker ☐ OR Defibrillator pacemaker ☐

PREOPERATIVE QUESTIONNAIRE

Do you have lungs related problems ?

Asthma:	Yes	☐	No	☐
Bronchitis	Yes	☐	No	☐
Pneumonia	Yes	☐	No	☐
Emphysema:	Yes	☐	No	☐
Cough/expectorations (sputum):	Yes	☐	No	☐
Pulmonary embolism:	Yes	☐	No	☐
Sleep apnea:	Yes	☐	No	☐
CPAP/home oxygen:	Yes	☐	No	☐
Tuberculosis:	Yes	☐	No	☐

Do you suffer from neurological problems?

Epilepsy/convulsions:	Yes	☐	No	☐
Paralysis/CVA:	Yes	☐	No	☐
Numbness:	Yes	☐	No	☐
Loss of consciousness:	Yes	☐	No	☐
Migraine:	Yes	☐	No	☐
Back pain:	Yes	☐	No	☐
Neck problems:	Yes	☐	No	☐
Spinal operation:	Yes	☐	No	☐

Do you suffer from digestive problems?

Gastric reflux:	Yes	☐	No	☐
Stomach ulcer:	Yes	☐	No	☐

Do you suffer from liver related problems (cirrhosis, hepatitis, jaundice)? Yes ☐ No ☐

Specify: _____

Do you suffer from blood related problems ?

Anemia:	Yes	☐	No	☐
Abnormal bleeding:	Yes	☐	No	☐
Frequent bruises :	Yes	☐	No	☐
Hemophilia:	Yes	☐	No	☐
Leukemia:	Yes	☐	No	☐
Thrombophlebitis:	Yes	☐	No	☐

In the past, have you ever received a blood transfusion? Yes ☐ No ☐

Any reaction(s) during the transfusion ? Yes ☐ No ☐

Specify: _____

PREOPERATIVE QUESTIONNAIRE

Do you suffer from?

Diabetes:	Yes ☐	No ☐	Muscular disorder :	Yes ☐	No ☐
Glaucoma:	Yes ☐	No ☐	Motion sickness :	Yes ☐	No ☐
Thyroid disorder:	Yes ☐	No ☐	Urinary tract infection :	Yes ☐	No ☐
Kidney disease:	Yes ☐	No ☐	Genital infection {herpes,etc.}	Yes ☐	No ☐
Adrenal gland disease:	Yes ☐	No ☐	HIV positive :	Yes ☐	No ☐
Pituitary disorder:	Yes ☐	No ☐	Hepatitis :	Yes ☐	No ☐
Rheumatoid arthritis:	Yes ☐	No ☐	Hepatitis : A ☐ B ☐ C ☐		

Other: _____

More questions related to your health condition:

Do your ankles swell ? Yes ☐ No ☐

Under nice weather condition, how long can you walk ? _____

When walking, do you have cramps in your legs ? Yes ☐ No ☐

If necessary, how many stairs would you be able to climb ? _____

Are you treated in another hospital ?

Yes ☐ No ☐

Specify: _____

Are you known by the CLSC ? (Quebec)

Yes ☐ No ☐

Which one ? _____

Patient's signature: _____

Date: _____

CMC RESERVED SECTION

Checked by the nurse : _____

Date: _____