College of Physicians & Surgeons of Alberta

# Preamble

Accreditation standards for Non-Hospital Surgical Facilities in Alberta require a documented history and physical examination on each patient within the 90-day period prior to a surgical procedure, and which is updated and signed within 2 weeks prior to that procedure. When the services of anesthesiologist will be necessary, then a pre-operative assessment by an anesthesiologist is also required. Although these often occur on the day of surgery, it remains best practice to ensure that each patient's peri-operative needs are determined well enough in advance of surgery to avoid surprises on the day of surgery.

To guide the content of pre-operative data collection, the NHSF accreditation advisory committee has prepared a sample ***Personal Health History*** to be completed by patients and guardians, and ***Medical History and Physical*** to be completed by physicians and surgeons. These forms are examples only and are NOT the required minimum NOR the complete data set suitable for all facilities. Facilities are encouraged to copy and adapt these forms for their use.

The committee appreciates the help of facilities and health authorities which provided copies of their forms for this project.


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# Personal Health History

Patient Name: _____ Date of Birth: _____

Please BRING this completed form:

- ❒ to your medical examination with your family physician;
- ❒ to the surgical facility on the day of surgery; OR
- ❒ MAIL this completed form to: _____

Are you: Fluent in English? Yes ❒ No ❒
Able to see, hear and walk without assistance? Yes ❒ No ❒

Sex: Male ❒ Female ❒ Are you currently pregnant? Yes ❒ No ❒

Height: _____ Weight: _____ Smoker within past year: Yes ❒ No ❒

| Allergies: |
|---|
| |
| |
| |

| Medication, herbal products, eye drops, non-prescription drugs used currently: |
|---|
| |
| |
| |

Have you ever used cortisone/steroids? Yes ❒ No ❒

| Past anesthesia and surgical procedures: | |
|---|---|
| | |
| | |

Do you have?

| | | | | | |
|---|---|---|---|---|---|
| Dentures | Yes ❒ | No ❒ | Caps on front teeth | Yes ❒ | No ❒ |
| Loose Teeth | Yes ❒ | No ❒ | Contact lenses | Yes ❒ | No ❒ |
| Hear Aid | Yes ❒ | No ❒ | Body Piercings | Yes ❒ | No ❒ |

Have you or any member of your family had any problems with anesthesia? Yes ❒ No ❒

Do you currently have or have you previously experienced any of the following medical problems?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| ▪ Heart attack | ❒ | ❒ | ▪ Fainting spells | ❒ | ❒ |
| ▪ Pacemaker | ❒ | ❒ | ▪ Diabetes | ❒ | ❒ |
| ▪ Other heart disease | ❒ | ❒ | ▪ Muscle disorders | ❒ | ❒ |
| ▪ High blood pressure | ❒ | ❒ | ▪ Kidney disease | ❒ | ❒ |
| ▪ Blood clots | ❒ | ❒ | ▪ Hepatitis | ❒ | ❒ |
| ▪ Chest pain | ❒ | ❒ | ▪ Tuberculosis | ❒ | ❒ |
| ▪ Stroke | ❒ | ❒ | ▪ HIV | ❒ | ❒ |
| ▪ Asthma | ❒ | ❒ | ▪ Heartburn /reflux | ❒ | ❒ |
| ▪ Other lung disease | ❒ | ❒ | ▪ Cancer | ❒ | ❒ |
| ▪ Difficulty breathing | ❒ | ❒ | ▪ Blood disorders | ❒ | ❒ |
| ▪ Sleep apnea or snoring | ❒ | ❒ | ▪ Rheumatic disease | ❒ | ❒ |
| ▪ Epilepsy or seizures | ❒ | ❒ | ▪ Anxiety disorders | ❒ | ❒ |

Other medical conditions or impairments: _____

_____

Date: _____ Information provided by: _____

Relationship to patient: _____


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# Medical History and Physical

**Incomplete Information May Result in a Delay of Surgery**

Patient Name: _____
Surname Given Name

Address: _____

_____

History

| Chief Complaint / Proposed Surgery |
|---|
| |

| Past Illness and Operations |
|---|
| |

| Cardiac | ❒ None |
|---|---|
| ❒ Hypertension | |
| ❒ MI | |
| ❒ Angina | |
| ❒ CHF | |
| ❒ Cardiac Arrhythmias | |

| Respiratory | ❒ None |
|---|---|
| ❒ Asthma | |
| ❒ COPD | |

| Endocrine | ❒ None |
|---|---|
| ❒ Diabetes | |
| ❍ Diet controlled | |
| ❍ oral Hypoglycemics | |
| ❍ Insulin controlled | |
| ❒ Thyroid | |

| GI / GU | ❒ None |
|---|---|
| ❒ Peptic ulcer | |
| ❒ Renal failure | |
| ❒ Malabsorption disorder | |
| ❒ GE Reflux | |

| Medications | ❒ None |
|---|---|
| | |

| Allergies | ❒ None |
|---|---|
| | |

| Pertinent Physical Examination |
|---|
| |

| Neck and Head | ❒ No significant abnormality |
|---|---|

| Heart | ❒ No significant abnormality |
|---|---|

| Lungs | ❒ No significant abnormality |
|---|---|

| Abdomen | ❒ No significant abnormality |
|---|---|

| Musculoskeletal | ❒ No significant abnormality |
|---|---|

| Pelvic | ❒ No significant abnormality |
|---|---|
| L.M.P. | |

| General Condition and Diagnosis |
|---|
| |

_____
Physician's Name

_____
Signature

_____
Date

*Date of review by surgeon or anesthetist:* _____
*(within 2 weeks of surgery)*

_____
*(signature)*


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