Peterborough Regional Health Centre
Surgery & Outpatient Procedures
1 Hospital Drive, Peterborough, ON K9J 7C6
(705) 743-2121 web: www.prhc.on.ca

Patient Label

	PATIENT ADMISSION QUESTIONNAIRE (PAQ)
Date of Birth (dd/mm/yy)	This form has 3 pages and is to be completed by Patient, Guardian or Substitute Decision Maker (SDM), and brought with you when you come to the hospital.
Scheduled Procedure Date & Time	**Please make sure your name is on all pages.**
Surgeon / Attending Physician	**Page 1 of 3**
Family Doctor	
Diagnosis	
Procedure	

Please check yes or no if you have, or ever had, any of the following:

Specialists			notes requested
Have you ever seen a Dr. for your **heart** ☐ No If yes, name of Dr.	Where:	When:	☐
Have you ever seen a Dr for your **lungs** ☐ No If yes, name of Dr.	Where:	When:	☐
Have you ever seen a Dr for your **kidneys** ☐ No If yes, name of Dr.	Where:	When:	☐
Have you ever seen a **Neurologist** ☐ No If yes, name of Dr.	Where:	When:	☐

Have you ever seen any specialists that you have not already listed? Yes ☐ No ☐

Have you been treated or hospitalized for any major illness or had surgery in the past? Yes ☐ No ☐

If yes, when, where, what type?

_____

_____

_____

Release of Patient Information

I _____ give consent for PRHC to retrieve my medical records from my Family Doctor / Specialist or medical facility as required for my care at PRHC.

_____ _____

Signature Date

This Area for Patient to check	Yes	No	SOP Nursing Assessment
Do you have an Advance Medical Directive? ie. Do Not Resuscitate (DNR) Status			
Have you or a family member had a problem with a previous local or general anesthetic?			
History of malignant hyperthermia (or a relative?)			
ENDOCRINE			SOP Nursing Assessment
Diabetes: ☐ Diet ☐ Pills ☐ Insulin ☐ Insulin pump			
Thyroid disease			
Could you be pregnant?			

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CARDIOVASCULAR	Yes	No	SOP Nursing Assessment
Do you have to stop to catch your breath when climbing 2 flights of stairs			
Angina, chest tightness or pain			
Heart attack (MI)			
Hypertension (high blood pressure) or take medication for this			
Heart failure			
Swelling of your ankles			
Pacemaker / ICD			
Irregular Pulse / Palpitations			
Heart Murmur			
Heart Surgery			
Stent			
Dizziness, Blackouts			
RESPIRATORY			
Do you smoke? If yes, how many per day for how many years			
Do you want to quit smoking?			
Have you ever smoked? When did you quit			
Difficulty breathing at night			
Asthma / cough / wheeze			
Tuberculosis			
Bronchitis			
Emphysema			
Shortness of breath			
COPD			
Sleep Apnea: ☐ Oral appliance ☐ IPAP ☐CPAP			
Have you had a cold recently			
GASTROINTESTINAL			
Heartburn / Hiatus Hernia (reflux)			
Difficulty swallowing			
Easily nauseated			
Jaundice / Liver disease			
Hepatitis if yes, type?			
GENITOURINARY			
Kidney problems			
Are you on Dialysis?			
NEUROLOGIC			
Stroke / TIA's			
Head injury			
Seizures or convulsions			
Confusion / Dementia			
Spinal Cord Problems			
Numbness or tingling arms or legs			
Muscle weakness			

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OTHER	Yes	No
HIV / AIDS		
Arthritis ☐ Osteoarthritis ☐ Rheumatoid		
Cancer Where?		
Anemia		
Bleeding disorder		
Do you drink alcohol /beer / wine?		
Have you had a blood transfusion?		
Emotional distress / anxiety		
TEETH		
Loose teeth		
Chipped teeth		
Dentures ☐ upper ☐ lower		
Permanent Bridge		
Bonded or capped teeth		
HEARING		
Hearing loss		
Hearing aids		

Current Medications (including herbal medications)

Name of Medication – Dose and Frequency	Name of Medication – Dose and Frequency

Do you have any medication allergies?

Name of medication	Reaction Example: Rash or hives or swelling etc	Comments (nursing)

Do you have any other allergies?
(e.g. Latex- rubber gloves, Food- nuts, bananas, shellfish, chestnuts Environmental – pollen, pets, grass)

Allergy	Reaction Example: Rash or hives or swelling etc	Comments (nursing)

Nurse's Signature	Initials	Date