HEALTH STATUS

INFORMATION FORM

COMPLEXE CHIRURGICAL
GrS MONTRÉAL

This form must be completed by the primary physician and the patient.
Please send us the completed form as soon as possible.

PATIENT IDENTIFICATION	
Name:	**Surname:**
Date of birth :	Health number :
Weight:________kg Height:________cm	BMI*:
* If BMI is between 35 and 40, please complete the attached obstructive sleep apnea (OSA) questionnaire and follow its recommendations.	
Surgical Procedure:	

PHYSICIAN'S INFORMATION	YES	NO	PRECISIONS
1. I am the doctor who regularly monitors this person's overall health.	☐	☐	Date of the last consult:
RESPIRATORY	**YES**	**NO**	
1. Does this person have any respiratory problems such as asthma, bronchitis COPD or emphysema?	☐	☐	
2. Does this person suffer from sleep apnea?	☐	☐	Does she use her sleep apnea device?
NEUROLOGY	**YES**	**NO**	
1. Has this person ever had a stroke?	☐	☐	Description of aftereffect :
2. Does this person have any neurological problems such as Parkinson’s disease, multiple sclerosis, spinal paralysis, etc.?	☐	☐	
ANESTHESIA	**YES**	**NO**	
1. Has this person ever had problems with anesthesia or had a reaction to it??	☐	☐	If so, please specify :
2. Does this person or someone related to this person suffer from malignant hyperthermia?	☐	☐	If so, please specify relation to this person :
CARDIAC AND VASCULAR	**YES**	**NO**	
1. Does this person have any cardiac problems such as congenital malformations, heart murmur, heart palpitations, heart failure, angina, heart attack, etc. ?	☐	☐	If so, does this person have a pacemaker, a defibrillator or a heart valve?

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HEMATOLOGY	YES	NO	PRECISIONS
1. Does this person suffer from any blood coagulation anomalies, hematological disorders or or anemia?	☐	☐	If so, please specify :
2. Has this person ever had phlebitis or a pulmonary embolism ?	☐	☐	
3. Does this person suffer from liver problems?	☐	☐	
RENAL	**YES**	**NO**	
1. Does this person have any kidney problems (chronic kidney disease, transplant, undergoes dialysis)?	☐	☐	If so, please provide the results of the patient's last renal checkup :
ENDOCRINOLOGY	**YES**	**NO**	
1. Is this person diabetic?	☐	☐	If so, please specify: ❑ Type 1 - ❑ Type 2 Please provide glycated hemoglobin assay. * To do if not available
MENTAL HEALTH - SUBSTANCE ADDICTION	**YES**	**NO**	
1. Does this person suffer from any mental health problems (depression, anxiety, bipolarity, schizophrenia, personality disorder, etc.)?	☐	☐	If so, please specify: Are the mental health issues resolved, controlled, or uncontrolled?
2. Does this person have addiction issues with medications, drugs, or alcohol?	☐	☐	If so, please specify the substance:
3. Has this person been hospitalized for mental health problems in the past year?	☐	☐	
OTHER	**YES**	**NO**	
1. Is there any other information you would like to share about this person's health?	☐	☐	

❑ I have reviewed this questionnaire with the patient and I acknowledge that the information it contains is complete and accurate.

Name of the physician who completed this form:

Signature:

Date :

MEDICAL RECORD © Complexe Chirurgical CMC, 2018