Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

Adult Pre-Surgical Screening Patient Assessment (PSS)

PART 1 - TO BE COMPLETED BY THE PATIENT / GUARDIAN

Pharmacy Name and location / phone number

	Please check "yes" or "no" if you have history of the following:	YES	NO	
HEART	Chest pain or angina			THIS SIDE FOR USE BY PSS NURSE ONLY
	Heart attack / Coronary Stent			
	Stroke / TIA (Mini stroke)			
	Do you have high blood pressure, or take medication for this			
	Irregular pulse / palpitations			
	Heart murmur / Rheumatic fever			
	Pacemaker / Implantable Cardioverter Defibrillator (ICD)			
	Heart failure			
	Do you have difficulty climbing one flight of stairs			
	Blood Clot legs or lungs			
	Any previous heart tests / heart surgery			THIS SIDE FOR USE BY PSS NURSE ONLY
LUNG	Shortness of breath with: Normal activity ☐ At rest ☐			
	Productive cough			
	Asthma / bronchitis / emphysema (COPD) / Reactive Airways disease			
	Pneumonia / tuberculosis			
	Do you smoke tobacco			
	Have you quit smoking			
	Do you have sleep apnea Oral appliance ☐ CPAP ☐ BIPAP ☐			
	Do you use oxygen at home			THIS SIDE FOR USE BY PSS NURSE ONLY
RENAL / GI	Kidney problems / dialysis / transplant			
	Heartburn / hiatus hernia (Acid reflux)			
	Easily nauseated / motion sickness			
	Hepatitis / jaundice / liver disease			THIS SIDE FOR USE BY PSS NURSE ONLY
OTHER	Diabetes Insulin ☐ Pills ☐ Diet ☐			
	Thyroid problems			
	Pituitary or Adrenal Disease			
	Arthritis Rheumatoid Arthritis ☐ Osteoarthritis ☐			
	Disease of nerves and muscles			
	Seizures			
	Have you had a fall within the last year			
	Mental Health problems			
	Significant memory loss			
	Cancer Chemotherapy ☐ Radiation ☐			THIS SIDE FOR USE BY PSS NURSE ONLY

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Adult Pre-Surgical Screening Patient Assessment

PART 1 (continued)- TO BE COMPLETED BY THE PATIENT / GUARDIAN

Please check "yes" or "no" if you have history of the following:

		YES	NO
OTHER	Anemia / bleeding disorders		
	At risk for Sickle-cell Disease (e.g. African or Caribbean descent)		
	Previous blood transfusion		
	Could you be pregnant at this time		
	Have you had an organ or bone marrow transplant		
	Drug Resistant Infection MRSA ☐		
	HIV / AIDS		
	Do you use recreational drugs		
	Do you drink caffeinated beverages (coffee, tea, cola)		
	Do you drink alcohol		
	Have you ever thought you ought to cut down on your drinking		
	Have people annoyed you by criticizing your drinking		
	Have you ever felt bad or guilty about your drinking		
	Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover. (eye opener)		
	Would you like to see a member of our pastoral care (spiritual care) team		
	Do you have an Advanced Directive (Living Will)		
TEETH	Do you have any loose teeth ☐ caps / bonding / bridges		
	Dentures: Upper Full ☐ Partial ☐ Lower Full ☐ Partial ☐		

THIS SIDE FOR USE BY PSS NURSE ONLY

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CAGE Score _____

PREVIOUS OPERATIONS / PROCEDURES

List your previous operations / hospitalizations (include approximate dates)

	YES	NO
History of allergy to latex or rubber		
Have you ever had a problem with local or general anesthetics		
Has anyone related to you ever had a problem with an anesthetic		
History of malignant hyperthermia (or any relative)		

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Speaks English Yes ☐ No ☐ Language

Hearing Impaired Yes ☐ No ☐ Interpreter required Yes ☐ No ☐

Daytime Phone Number: _____ Best time to call: _____

Completed by: Patient ☐ Guardian ☐ Registered Nurse (R.N.) ☐ Other ☐

Printed Name _____ Designation _____

Signature _____ Date (yyyy/mm/dd) _____ Time (hhmm) _____

Printed Name _____ Designation _____

Signature _____ Date (yyyy/mm/dd) _____ Time (hhmm) _____

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Adult Pre-Surgical Screening Patient Assessment

PART 2 - TO BE COMPLETED BY PSS NURSE

Assessment completed Telephone ☐ On Site ☐

THIS PAGE TO BE COMPLETED BY PSS NURSE ONLY

	Medication Name *(use generic names if possible)*	Dose	Route	Frequency / Comments See Progress Notes ☐
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

Allergies / Adverse Reactions **Symptoms** **Allergies / Adverse Reactions** **Symptoms**

None Known ☐

1.		4.	
2.		5.	
3.		6.	

Nutrition

Special diet Yes ☐ No ☐ _____

Recent weight change Yes ☐ No ☐ _____

Elimination

Continent ☐ Incontinent ☐ Other ☐ _____

Present bowel pattern _____

Mobility Normal ☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair ☐

Assistance with None ☐ Moving in bed ☐ Stairs ☐ Eating / drinking ☐ Bathing / hygiene ☐

Prosthetics None ☐ Glasses / contact lenses ☐ Hearing Aid Left (L) ☐ Right (R) ☐

Body piercing ☐ _____ Other / Comments ☐ _____

Pain Do you suffer from chronic pain Yes ☐ No ☐

Score: 0 (no pain) - 10 (excruciating) 0 1 2 3 4 5 6 7 8 9 10 Location _____

Infection Risk

Admitted to other health care facilities in last six months Yes ☐ No ☐ Contact with communicable disease in last 30 days Yes ☐ No ☐