Shouldice Hospital
7750 Bayview Avenue
Thornhill, ON L3T 4A3
Tel: 905-889-1125 Fax: 905-889-4216
Toll Free: 1-800-291-7750

MEDICAL INFORMATION QUESTIONNAIRE

For patients living at a distance, this Medical Questionnaire can help you arrange your examination, admission and surgery all in one visit. However, it is only after the personal examination at our Clinic that a final diagnosis and treatment plan can be made.

The completion and return of this Questionnaire will not put you under any obligation whatsoever.

Please be sure to answer *ALL* questions and all sections.

THIS FORM CAN BE COMPLETED ON YOUR COMPUTER AND SAVED, THEN EMAILED BACK TO OUR OFFICE. THE EMAIL ADDRESS IS medicalquestionnaire@shouldice.com

If you do not wish to email this form for reasons of internet confidentiality, please fax or mail the printed Form to the Hospital.

On receipt by Shouldice Hospital, all information will be treated as confidential. Please allow 2-3 business days for a Shouldice Surgeon to review and respond to your Questionnaire.

ALL QUESTIONS MUST BE ANSWERED ACCURATELY – please print clearly.
Incomplete or inaccurate answers may necessitate delay or cancellation of surgery. If in doubt, please consult your family physician.

Section A

Family Name *(Last Name)*:	Friedman		
First Name/Initial:	Barry L		
Address:	480 Tweedsmuir Ave,		
City:	Ottawa		
Province/State:	Ont.	Postal Code/Zip:	K1Z 5N9
Home Phone *(999-999-9999)*:	613-725-3198	Birth Date *(dd/mm/yyyy)*:	06/10/1946
Gender	☑ Male ☐ Female	Language:	English
Marital Status:	☑ Married ☐ Single ☐ Divorced ☐ Widowed		
Email Address:	bfriedman@emax.ca		
Emergency Contact:		Telephone *(999-999-9999)*:	

Have you had surgery at Shouldice Hospital before?	☐ Yes ☑ No	If yes, what year?	
Have you previously been examined at Shouldice Hospital or submitted a medical questionnaire?			☐ Yes ☑ No
Occupation/Retired:	Computer Tech	Cell Phone No. (999-999-9999)	613-261-0767
Name of Employer:		Business Phone No. *(999-999-9999)*:	613-725-3198

Height-barefoot(feet/inches)	5/10	Current weight – nude(pounds)	190	Recent weight gain (pounds)	
Recent weight loss (pounds)		Waist at the navel,relaxed (inches)		Chest-not expanded (inches)	

What is your preferred admission date?		Preferred method of communication:	☐ Mail ☑ Email

(*Please give as much advance notice as possible. There are no admissions on Friday or Saturday. Sunday admissions are reserved for those patients who have previously been examined at Shouldice Hospital. All admissions are one day prior to surgery.)*

How did you hear about Shouldice Hospital?	☐ Friend ☐ Article ☐ Medical Doctor ☐ Internet ☑ Other

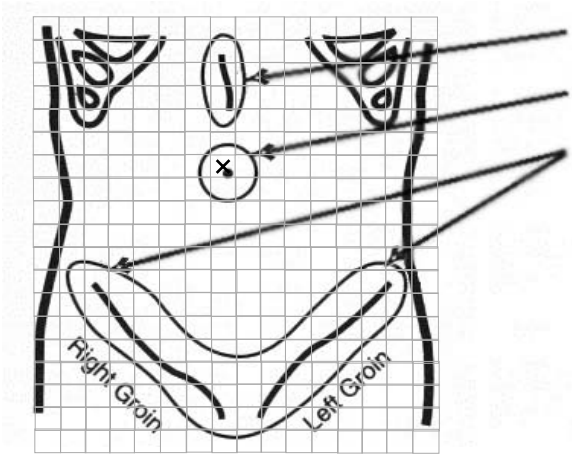
Name, address and phone number of family physician to contact should additional medical information be required:

Name:	Schneider, G. Dr
Address:	474 Holland Ave,
City:	Ottawa,
Province/State:	ON
Postal/Zip:	K1Y 0Z5
Telephone:	613-729-1608
Fax:	

TO BE COMPLETED BY ONTARIO PATIENTS ONLY	
Health Card Number:	4353-608-294-WE
Is this a Workers' Compensation Case?	☐ Yes ☑ No

Section B

Place a checkmark on the position of each hernia you want repaired:



(Hiatus, Flank and Parastomal Hernias are not repaired at Shouldice Hospital)

EPIGASTRIC Hernias are above the navel ("belly button")

UMBILICAL Hernias are at the navel.

INGUINAL AND FEMORAL HERNIAS are in the groin area on either side.

INCISIONAL Hernias bulge through the scar of any other type of surgical operation that has failed to hold.

OTHER Hernias are through any other muscular weakness.

Section C

DESCRIBE *ONLY* THE HERNIAS THAT YOU WANT REPAIRED

INGUINAL and FEMORAL HERNIAS			
Right Groin			
Is this your first **RIGHT** groin hernia?	☐ Yes ☐ No	If no, number of previous **RIGHT** repairs?	
Date of last repair *(m/y)*:		Can you reduce *(push back in)* your hernia?	☐ Yes ☐ No
Size of hernia:	☐ No noticeable bulge ☐ Walnut (or less) ☐ Hen's egg ☐ Grapefruit (or more)		
Left Groin			
Is this your first **LEFT** groin hernia?	☐ Yes ☐ No	If no, number of previous **LEFT** repairs?	
Date of last repair *(m/y)*:		Can you reduce *(push back in)* your hernia?	☐ Yes ☐ No
Size of hernia:	☐ No noticeable bulge ☐ Walnut (or less) ☐ Hen's egg ☐ Grapefruit (or more)		
UMBILICAL, EPIGASTRIC and OTHER HERNIAS			
Is this your first UMBILICAL, EPIGASTRIC/OTHER hernia?	☑ Yes ☐ No	If no, number of previous repairs?	
Date of last repair *(m/y)*:		Can you reduce *(push back in)* your hernia?	☑ Yes ☐ No
Size of hernia:	☐ No noticeable bulge ☐ Walnut (or less) ☑ Hen's egg ☐ Grapefruit (or more)		
INCISIONAL HERNIAS			
What was the original operation for:	☐ Appendix ☐ Gall Bladder ☐ Stomach ☐ Caesarian ☐ Hysterectomy ☐ Colon ☐ Other _____		
How many previous repairs have been attempted on this hernia?		Date of last repair *(dd/mm/yyyy)*:	
Size of hernia:	☐ No noticeable bulge ☐ Walnut (or less) ☐ Hen's egg ☐ Grapefruit (or more)		

ADDITIONAL INFORMATION ABOUT YOUR HERNIA	
Has the hernia(s) identified above been diagnosed by a medical doctor?:	☑ Yes ☐ No *(Self Diagnosed)*
If yes how?	☑ Physical Exam ☐ Ultrasound ☐ Other _____
Are you experiencing chronic pain from the hernia(s) identified above?	☐ Yes ☑ No
Are you experiencing any chronic pain from a previous hernia repair?	☐ Yes ☑ No
Have you experienced a wound infection in any previous surgery?	☐ Yes ☑ No
Was mesh used in your other prior hernia surgery?	☐ Yes ☐ No

Section D

HAVE YOU EVER HAD, PAST OR PRESENT …

	YES	NO	?	DETAILS to all Questions answered yes
1. an abnormal reaction to a local or general anesthetic or history of malignant hyperthermia?	Y	☑	?	
2. a family member that has had an abnormal reaction to anesthetic?	Y	☑	?	
3. heart trouble, heart attack, angina, mechanical valves or irregular heart beat?	Y	☑	?	
4. abnormal blood pressure, high or low?	Y	☑	?	
5. medicine for your heart or high blood pressure?	Y	☑	?	
6. difficulty with breathing or had unusual tiredness or weakness?	Y	☑	?	
7. lung illness, asthma, emphysema, chronic bronchitis, or tuberculosis?	Y	☑	?	
8. medicine for asthma or other lung illness?	Y	☑	?	
9. kidney illness or problems with urination?	Y	☑	?	
10. severe or unusual bleeding following any trauma, cut or dental extraction?	Y	☑	?	
11. a blood disorder *(high or low platelets, hemoglobin or white cells)*?	Y	☑	?	
12. blood clots in the legs *(DVT)* or in the lungs *(pulmonary embolism)*?	Y	☑	?	
13. diabetes or abnormal blood sugar ?	Y	☑	?	
14. problems with digestion, bowel function, bleeding or vomiting?	Y	☑	?	
15. jaundice, hepatitis, cirrhosis, or ascites *(fluid in the abdomen)*? When? Type?	Y	☑	?	
16. a sexually transmitted disease or been exposed to/tested positive for HIV?	Y	☑	?	
17. steroids, prednisone, cortisone, ACTH, or related medicines?	Y	☑	?	

	YES	NO	?	DETAILS to all Questions answered yes
18. a stroke, unusual dizziness, blackouts, tremors or memory loss?	Y	✔	?	
19. Do you have any neurological disorders *(e.g. Parkinson's, Epilepsy, Dementia)*?	Y	✔	?	
20. Do you have any neuromuscular disorders *(e.g. Myasthenia gravis, Multiple sclerosis)*?	Y	✔	?	
21. Do you have any loose teeth? Capped teeth? False teeth?	Y	✔	?	
22. Do you have problems with eyesight or wear contact lenses?	✔	N	?	Myopia
23. Do you smoke? How much per day?	✔	N	?	10
24. Do you cough or have sputum from smoking?	Y	✔	?	
25. Do you use street or recreational drugs or are you on a drug maintenance program?	Y	✔	?	
26. Do you drink alcohol? How much per week?	✔	N	?	3-4 oz.
27. Do you have cultural or religious practices or requirements that we should know of?	✔	N	?	Kosher diet
28 Do you have any special needs or require supervision or attendant care *(e.g. vision, mobility, dietary, Down's or Tourette's Syndrome)*?	Y	✔	?	
29. Do you live alone or live in a retirement or nursing home?	Y	✔	?	
30. Are you allergic to anything *(e.g. medication, food, environmental, latex)*?	Y	✔	?	
31. Are you pregnant or within 12 months of an end of pregnancy?	Y	✔	?	
32. Have you undergone chemotherapy in the past 12 months?	Y	✔	?	
33. Have you undergone radiation therapy near your hernia in the past 12 months?	Y	✔	?	
34. Can you climb two flights of stairs without shortness of breath?	✔	N	?	
35. How do you rate your health NOW?	✔ GOOD	☐ FAIR	☐ POOR	

Section E

List ALL medicines taken in the past six months (including anything with aspirin and non-prescription or naturopathic medicines).

A-C-C occasionally

Please list all prior surgeries by date (specifying those done laparoscopically) and other significant illnesses:

Patient Acknowledgment

By checking this box ➔ ☑ You acknowledge that the information given above is accurate to the best of your knowledge.			
Patient Name	Barry Friedman	Date	9/9/2015

In addition, please ensure the **MRSA Screening Form** on Page 7 is also completed.

For Hospital Use Only

Date Received:	mm / dd / yy
Pre-Admission (completed by Shouldice Surgeon**)**	
Type of Hernia	
Admit: ☐ ***Yes,*** with ☐ ***No,*** unsuitable ☐ **Pending**, with	
Weight loss required	☐ *Yes* ☐ *No* ..... pounds
Medical reports required	☐ *Yes* ☐ *No* *If yes, what?:* .....
Approved by:	Date:
Admission Assessment by: ☐ Surgeon ☐ GP ☐ Nurse	
Approved by:	Date:

SHOULDICE HOSPITAL

SCREENING for
Influenza-Like Illness (ILI) and Antibiotic-Resistant Organism (ARO) / Methicillin-Resistant Staphylococcus Aureus (MRSA)

Please complete and submit this form to be considered for admission, in addition to the Medical Questionnaire.
Failure to follow these procedures will result in delay or cancellation of surgery.

Print Patient's Full Name Barry Lawrence Friedman

Please answer all questions below, then sign and date.
Any new health issues and/or operations between the time of completing this form and your date of admission must be reported to the Hospital at least 2 weeks before your admission to update your information.

A. 1. Do you have new / worse than usual cough, shortness of breath, sore throat, severe headache?
☐ Yes (please circle symptoms) ☑ No

2. Are you feeling feverish, or have you had fever, shakes or chills, muscle aches within the last 24 hours?
☐ Yes (please circle symptoms) ☑ No
* A Nurse will check your temperature on admission_____ °C

3. Travel and Contact History:
a) Have you traveled to places outside Canada within the last 21 days?
☑ Yes Country U.S.A. ☐ No

b) Have you had contact with a sick person who has traveled outside Canada within the last 21 days?
☐ Yes Country_____ ☑ No

B. 4. Have you been admitted to a different hospital for at least 24 hours within the past 12 months?
☐ Yes ☑ No

5. Are you a resident of a Long Term Care facility? (Nursing home, group retirement home, rehab, etc.)
☐ Yes ☑ No

6. Have you worked in a facility that has had an outbreak of acute respiratory illness, gastro-intestinal illness or ARO/MRSA within the past year? ☐ Yes ☑ No

7. Have you been prescribed more than one type of antibiotics within the past year? ☐ Yes ☑ No
If yes, when?_____ For how long? _____

8. Have you been told that you have had any ARO such as MRSA, VRE(Vancomycin Resistant Enterococcus), or C-diff. (Clostridium difficile)?
☐ Yes ☑ No

9. Have you had any vomiting, diarrhea, stomach pain recently? ☐ Yes ☑ No

Signature of Patient or Substitute Decision Maker: _____
Date: _____
By checking this box, you acknowledge that the information you have given is true. ☑

Front Office Nurse: Practice/promote **Hand Hygiene** at all times & **Respiratory Precautions** as necessary!
- Review this questionnaire upon receipt and on admission with patient for any changes to health. Any "**yes**" answers need to be referred to the Examining Physician for in-depth assessment and/or further orders.
- Refer to guideline for management of ILI and/or ARO/MRSA screening and for detailed precautionary measures.

Date of Initial Assessment: _____ Nurse Signature _____
Date of Admission/Review: _____ Nurse Signature_____
Patient Signature_____
Notes:_____
_____