New Patient Health Questionnaire

Dr. Patrick McCrea, General Surgeon

Boardwalk Professional Centre, 220 Water Street, Charlottetown, PEI, C1A 9M5
Phone: 902-368-7610 Fax: 902-368-7611
E-mail: info@drpatrickmccrea.com Website: www.drpatrickmccrea.com

This questionnaire may take some time to fill out but it is important to your health care. If this form is difficult for you to complete, you should ask a family member or friend for help *and* you should bring them to your appointment. Please return by email, fax, mail, or hand delivery at least one week prior to your appointment. You may receive a phone call to clarify answers. You are sharing personal information which the clinic keeps strictly confidential. *The security of any method by which information is delivered to the clinic is the responsibility of the patient*.

Part A: Personal & Contact Information			
Name:		Today's date (dd,mm,yyyy):	
Home Phone:		Cell Phone:	
Work Phone:		E-mail:	
Home Address:			
Height: ☐cm ☐in	Weight: ☐kg ☐lb	Sex: ☐ M ☐ F	Date of birth (dd,mm,yyyy):
Primary/Emergency Contact:		Relationship:	
Home Phone:		Cell or Work Phone:	

Part B: Planning, Beliefs, and Directives	
Would you have someone to take you home and stay with you after a surgery? (If you answered "no", you must make arrangements or your surgery will be cancelled.)	☐ Yes ☐ No
Is there any chance that you could be pregnant?	☐ Yes ☐ No
Do you have plans to have (further) children?	☐ Yes ☐ No
Do you have a living will (i.e., care directives should you become unwell in hospital)?	☐ Yes ☐ No
Do you have a Power of Attorney for Personal Care?	☐ Yes ☐ No
If you need a blood transfusion, would you accept it?	☐ Yes ☐ No

Part C: Referral Information **(please mark all that apply and add additional details as needed)**		
Why have you been referred to Dr. McCrea?		
Referring Physician:	Phone:	
Family Physician:	Phone:	
Please list below, any other Physicians that you have seen in the **last 5 years**:		
Physician/Specialty	**Phone**	**Medical Condition**
1.		
2.		
3.		
4.		
Have you had any investigations (radiological, blood tests, stress tests, etc.) outside Charlottetown or the Queen Elizabeth Hospital in the past 5 years? If so, please state any location(s):		☐ Yes ☐ No

Part D1: Breast Health (please fill out ONLY if referred for breast-related issues)

Why are you being referred?	What are your symptoms?		Where are your findings (if known)?	
☐ Finding on screening Mammogram	☐ Pain/Tenderness	☐ Lump	☐ Left Breast	☐ Right Breast
☐ Change on self-breast exam	☐ Skin Dimpling/Puckering	☐ Redness	☐ Left Nipple	☐ Right Nipple
☐ Change on Physician exam	☐ Nipple Discharge	☐ No symptoms	☐ Left Armpit	☐ Right Armpit
☐ Other	☐ Nipple retraction (new)	☐ Other		

Hormone Related Factors	At what age did your menstrual cycle start? What was the start date of your last menstrual cycle? (dd,mm,yyyy)
	Number of pregnancies: Number of Childbirths: Your age at first childbirth: Total time you breastfed (yrs):
	How many total years have you taken birth control pills (0 if never): How many total years have you taken hormone replacement therapy (HRT) (0 if never): If you have taken HRT, what was the name of the medication?

Do you have any history of breast cancer?	☐ Yes ☐ No	Do you have breast implants?	☐ Yes ☐ No
Do you have any history of breast biopsies?	☐ Yes ☐ No	Do you plan on having (more) children?	☐ Yes ☐ No
Have you had surgery following a biopsy?	☐ Yes ☐ No	Do you have regular mammograms?	☐ Yes ☐ No

Part D2: Thyroid and Parathyroid (please fill out ONLY if referred for thyroid or parathyroid issues)

Neck Symptoms and History ☐ No Symptoms	☐ Known thyroid nodule ☐ Known goiter (enlarged thyroid) ☐ Prior inflammation (thyroiditis) ☐ New or changing lump(s) in middle neck ☐ New or changing lump(s) on side of neck ☐ New or changing lump(s) under jaw, above collar bone, or under armpit ☐ Neck pain ☐ Change in voice ☐ Trouble swallowing ☐ New wheezing with breathing

General Symptoms ☐ No Symptoms				
	☐ Palpitations	☐ Menstrual Problems	☐ Cold intolerance	☐ Bone Fractures
	☐ Nervousness	☐ Poor memory	☐ Weight gain	☐ Kidney Stones
	☐ Heat intolerance	☐ Headaches	☐ Depression	☐ Muscle aches
	☐ Diarrhea	☐ Recurrent infections	☐ Constipation	☐ Abdominal Pain

Additional Factors ☐ No Factors	☐ Previous radiotherapy to neck as a child ☐ Accidental radiation exposure (nuclear accident) ☐ Personal or Family History of Thyroid Cancer, Hyperparathyroid, or Pheochromocytoma ☐ Personal or Family History of Familial Adenomatous Polyposis (FAP)

Part D3: Skin Lesions (please fill out ONLY if referred for moles or skin lesions)

Lesion Character	☐ Unusual shape ☐ Uneven boundaries ☐ Multiple colors ☐ Larger than 5mm ☐ Changing features
Prior History and Exposure	☐prior melanoma or "dysplastic nevi" ☐ multiple moles on body (>50) ☐ relative with melanoma ☐ tanning bed use ☐ previous severe sunburn ☐ fair skin ☐ use of immunosuppressant

Part D4: Pilonidal Disease (please fill out ONLY if referred for pilonidal disease)

Conditions	☐ Pain ☐ Swelling ☐ Redness ☐ Drainage of Pus ☐ Hair in area
Prior Treatments	☐ Antibiotics ☐ Laser Hair Removal ☐ Prior Surgical Drainage ☐ Prior Surgical Repair

Part D5: In-grown Toenails (please fill out ONLY if referred for in-grown toenails)

Symptoms and Prior Treatments	☐ Pain at nail margin ☐ Pain with pressure ☐ Swelling/Redness at nail base ☐ Drainage from nailbed ☐ Previous excision ☐ Antibiotic Treatment

Part D6: Lumps and Bumps (please fill out ONLY if referred for lumps and bumps under the skin)

Details and Location	☐ Painful ☐ Increasing Size ☐ Previously Removed ☐ Interferes with Activities ☐ Left Arm ☐ Left Leg ☐ Right Leg ☐ Right Arm ☐ Chest ☐ Abdomen ☐ Back ☐ Head

Part E: General Symptoms and Further Details (please add any additional symptom details)

General Issues	☐ unintentional weight loss ☐ fatigue ☐ bone pain ☐ groin or armpit swelling ☐ fever/night sweats

Details or comments:

Part F: History of Cancer (please mark all that apply and add details as needed) ☐ NO ISSUES					
☐ melanoma	☐ colon	☐ rectal	☐ brain	☐ oral or throat	☐ sarcoma
☐ other skin cancer	☐ stomach	☐ anal	☐ breast	☐ thyroid	☐ lymphoma
☐ lung	☐ pancreas	☐ liver	☐ ovarian	☐ kidney	☐ leukemia
☐ prostate	☐ esophagus	☐ gallbladder	☐ uterine	☐ bladder	☐ Other
Please detail treatment dates & types (i.e., surgery, radiation, chemotherapy) as well as complications and cancer status:					

Part G: Medical and Surgical History (please mark all that apply and add details as needed)				
Head/Neck and Brain ☐ NO ISSUES	☐ stroke	☐ depression/anxiety	☐ dentures	☐ sleep apnea
	☐ epilepsy	☐ spinal cord injury	☐ head injury	☐ other
Details or comments:				
Heart and Lung ☐ NO ISSUES	☐ heart attack/MI	☐ angina	☐ asthma	☐ Tuberculosis
	☐ atrial fibrillation	☐ pacemaker	☐ COPD/emphysema	☐ pneumonia
	☐ heart murmur	☐ high blood pressure	☐ heart failure	☐ other
Details or comments:				
Sexual, Urinary, Skin, and Musculoskeletal ☐ NO ISSUES	☐ kidney disease	☐ urinary infections	☐ psoriasis	☐ osteoporosis
	☐ kidney stones	☐ STDs	☐ endometriosis	☐ osteoarthritis
	☐ Peripheral Vascular Disease		☐ lymphedema	☐ other
Details or comments:				
Liver/Gastrointestinal ☐ NO ISSUES	☐ hepatitis	☐ hiatus hernia	☐ Crohn's disease	☐ ulcers
	☐ cirrhosis	☐ acid reflux/GERD	☐ ulcerative colitis	☐ pancreatitis
	☐ perianal fistula	☐ anal fissure	☐ Proctitis	☐ gallstones
	☐ perianal abscess	☐ perianal warts	☐ Diverticulitis	☐ other
Details or comments:				
Blood, Metabolism, Endocrine, & Immune ☐ NO ISSUES	☐ blood clot (PE/DVT)	☐ hemophilia	☐ diabetes	☐ hypothyroid
	☐ sickle cell anemia	☐ anemia (other)	☐ high cholesterol	☐ autoimmune diseases
	☐ other blood disorder (family or personal)		☐ HIV/AIDS	☐ other
Details or comments:				
Gastrointestinal and Abdominal Surgery ☐ NO PRIOR SURGERY	☐ Appendix	☐ Colon or Rectum	☐ Ulcer Surgery	☐ Hysterectomy
	☐ Gallbladder	☐ Spleen	☐ Incisional Hernia	☐ Caesarean Section
	☐ Prostate Resection	☐ Trauma	☐ Umbilical Hernia	☐ Hemorrhoid
	☐ Prostate (TURP)	☐ Bariatric	☐ Inguinal Hernia	☐ Other
Details or comments:				
Other Surgeries ☐ NO PRIOR SURGERY	☐ Back surgery	☐ Dental	☐ Coronary Stenting	☐ Lung
	☐ Arm/Leg Fracture	☐ Tonsils	☐ Coronary Bypass	☐ Breast Surgery
	☐ Hip	☐ Thyroid	☐ Carotid Artery	☐ Other Blood Vessels
	☐ Knee	☐ Cataract	☐ Varicose Veins	☐ Other
Details or comments:				
Further Details and Other Conditions (Please add any unlisted diseases or surgeries) ☐ NO ISSUES				

Part H: Previous Hospitalizations (overnight starting with most recent) ☐ NO PRIOR HOSPITALIZATIONS

Date(dd,mm,yyyy) & Days in Hospital	Surgery/Illness	Physician/Hospital	Complications
1.			
2.			
3.			
4.			
5.			

If you have been in the hospital, have you ever tested positive for a resistant bacteria or "super-bug" such as MRSA (Methicillin-resistant *Staphylococcus aureus*) or VRE (Vancomycin-resistant *Enterococcus)*?	☐ Yes ☐ No

Part I: Medication History (you may contact your pharmacist for help)

Pharmacy Name: Phone: Fax:

Pharmacy Address:

Please list any medications you are **currently taking** (including over-the-counter drugs, puffers, insulin, herbals, eye drops, vitamins etc.). Each medication should be related to a documented medical condition; if you are unsure why you are taking a medication, please clarify with your pharmacist, regular physician, or naturopath.

Name of Medication	Frequency/Dosage (Prescribed)	Medical Condition being Treated	Date started or Dose Changed (dd,mm,yyyy)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Please list any medications you have **taken in the past** (including over-the-counter drugs, puffers, insulin, herbals, eye drops, vitamins etc.) including **the date stopped**.

Please list any medication, food, or environmental agent that you have a documented or suspected allergy

☐ No Known Allergies

Name of Medication	Date Stopped	Allergen	Reaction/Side Effect
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	

Part J: Additional Health Issues and Daily Life

General Health Symptoms

☐ NO ISSUES

☐ falls/poor balance	☐ seizures	☐ memory loss	☐ weakness
☐ leg swelling	☐ chest tightness	☐ persistent cough	☐ shortness of breath
☐ trouble breathing when lying flat		☐ calf pain or cramping while walking	
☐ recurrent infections	☐ wheezing	☐ excessive bruising	☐ other

Details or Comments:

Exercise Tolerance

Which statement most closely represents your level of activity?

☐ Aerobic exercise for more than 30 min, 3 or more times/week
☐ Occasional aerobic exercise for more than 15 min
☐ Non-aerobic exercise including walking
☐ Sedentary but able to walk 2 flights of stairs without fatigue
☐ Sedentary and fatigued by walking 2 flights of stairs
☐ Sedentary and unable to walk 2 flights of stairs because of fatigue
☐ Sedentary and fatigued by walking within the house

Daily Activities

☐ NO ISSUES

Do you have any difficulty with independent care of (check all that apply):

☐ Shopping	☐ Housekeeping	☐ Toileting	☐ Hygiene	☐ Vision
☐ Accounting	☐ Food Preparation	☐ Dressing	☐ Walking	☐ Hearing
☐ Use of telephone	☐ Transportation	☐ Bathing	☐ Medications	☐ Other Tasks

Please specify any aids or help you need for the above tasks or if you have any additional social, living, or occupational issues that have not been addressed:

Living and Working

Are you currently employed (including childcare)?
☐ Yes, full time ☐ Yes, part time ☐ Disability ☐ Worker's Compensation ☐ Retired ☐ Unemployed
What is/was your profession?

What is your current living situation?
☐ Independent (alone) ☐ Partner ☐ Family ☐ Assisted Living ☐ Nursing Home ☐ Other

Do you have any spiritual or religious beliefs that you would like medical staff to know?
Details or comments:

Tobacco, Alcohol, and Drugs

Please check off any tobacco product you have ever used. Under each state the quantity you are using now (e.g., 1 pk/day), the peak quantity you used on a regular basis (e.g., 2 pks/day), the total years of use, and the number of years quit. Active tobacco users enter "0" under the number of years quit.

Product used	☐ Cigarettes	☐ Chew	☐ Pipe	☐ Cigars
Current quantity/day	pks	#	#	#
Peak quantity/day	pks	#	#	#
Total years use	yrs	yrs	yrs	yrs
Number of years quit	yrs	yrs	yrs	yrs

How many alcohol drinks do you consume per week (one=12oz beer, 5oz wine, 1oz liquor)? #

Do you use street or recreational drugs (including Marijuana) and if yes, please list: ☐ Yes ☐ No

Has drug or alcohol use ever caused problems in your relationships or work life? ☐ Yes ☐ No
Details or Comments:

Part K: Family Medical History

Have you or a family member had any problems with anesthetics (other than nausea/vomiting)?	☐ Yes ☐ No
Is there any genetic conditions within your family (please specify)?	☐ Yes ☐ No

Please list and specify any known cancers (e.g., breast, colon, rectal, etc.) within your family.

Relative	**Cancer/Illness and Age at Diagnosis**	**Relative**	**Cancer/Illness and Age at Diagnosis**
Father		Child ☐ M ☐ F	
Mother		Child ☐ M ☐ F	
Sibling ☐ M ☐ F		Child ☐ M ☐ F	
Sibling ☐ M ☐ F		Grandmother (maternal)	
Sibling ☐ M ☐ F		Grandfather (maternal)	
Sibling ☐ M ☐ F		Grandmother (paternal)	
Sibling ☐ M ☐ F		Grandfather (paternal)	

Part K: Additional Information (please add any other information that you would like to share)