

PATIENT HEALTH HISTORY

PHYSICIAN'S NAME _____ SURGERY DATE _____

EVALUATION:

1. Height _____ Weight _____
2. Activity Level: Low (Light Housework) Moderate (Walk Up a Hill) High (Strenuous Sports)
- | | YES | NO | SPECIFY |
|---|--------------------------|--------------------------|---------|
| 3. Is your physical activity ever limited due to shortness of breath or chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Do you use Oxygen or a C-Pap machine at home? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Have you or any member of your family ever had a bleeding disorder? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Have you or any family member ever had a history of problems with anesthesia? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 7. Any allergies to medications or any unusual drug reactions?
Please list _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
8. Do you smoke or did you smoke? Yes No Packs/Day? _____ How many years? _____ Stopped _____
9. Do you drink alcohol? Yes No If so, how much? _____
10. Do you use recreational drugs? Yes No What kind? _____
11. Do you have any significant illness or injury? _____
12. Do you take any medications regularly? Yes **PLEASE LIST ON MEDICATION SUMMARY FORM.** No
13. Have you taken any Aspirin, Ibuprofen, Coumadin, Plavix, or Aggrenox in the last two (2) weeks? Yes No

Have you now or have you ever had?	YES	NO	Have you now or have you ever had?	YES	NO
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Implantable devices/pacemaker/defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in the legs	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer – list type _____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C, or MRSA bacterial infection, or HIV	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems (cuts, rashes, open sores)	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease/heart attacks/heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/dizziness/blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Facial fractures	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Recent cold <input type="checkbox"/> Infection	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal hernia/heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Dentures <input type="checkbox"/> Partials <input type="checkbox"/> Crowns <input type="checkbox"/> Caps	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Loose <input type="checkbox"/> Broken <input type="checkbox"/> Chipped teeth <input type="checkbox"/> Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>

Have you been hospitalized in the last year? Yes No If yes, why? _____

Previous Surgeries (When): _____

Do you have an Advance Directive/Health Care Power of Attorney? Yes No Would you like information? _____

Do you have a DNR (Do Not Resuscitate) or a POLST (Physician Order Life Supporting Treatment)? Yes No

If yes, bring the DNR or POLST with you the day of surgery.

In the last year, have you been hit, slapped, or otherwise physically hurt by someone? Yes No

Do you ever fear for your safety or for the safety of your family members? Yes No

Would you like to talk to someone privately or get information about help/resources for domestic violence? Yes No

Females: Could you be pregnant? Yes No Date of last period _____ Hysterectomy? Yes No

Anesthesia in the 1st trimester can cause miscarriage. A pregnancy test will be performed if you are of childbearing age.

Patient's Signature _____ Date _____



PATIENT LABEL

