PATIENT HEALTH HISTORY

YOUR NAME: _____

PHYSICIAN'S NAME: _____ PROCEDURE 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?	☐	☐	_____
4. Do you use Oxygen or a C-Pap machine at home?	☐	☐	_____
5. Have you or any member of your family ever had a bleeding disorder?	☐	☐	_____
6. Have you or any family member ever had a history of problems with anesthesia?	☐	☐	_____
7. Allergies = Your nurse will go over them.	☐	☐	

8. Medication you take regularly = Your nurse will go over them (We have a list from your doctor).
9. Have you taken any Aspirin, Ibuprofen, Coumadin, Plavix, or Aggrenox in the last two (2) weeks? ☐ Yes ☐ No
10. Do you smoke or did you smoke? ☐ Yes ☐ No Packs/Day? _____ How many years? _____ Stopped _____
11. Do you drink alcohol? ☐ Yes ☐ No If so, how much? _____
12. Do you use recreational drugs? ☐ Yes ☐ No What kind? _____
13. Do you have any significant illness or injury? _____

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

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

Please list 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 (age 10 - no menses).

Patient's Signature _____ Date _____

8600338 (10/18)

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PATIENT LABEL

DT0234