PATIENT NAME:	PREFERRED NAME:	PHONE #	AGE	HT.	WT.

REASON FOR ADMISSION/ NAME OF PROCEDURE	PROCEDURE DATE	DOCTOR	PRIMARY CARE PHYSICIAN

PLEASE LIST ALL PREVIOUS HOSPITALIZATIONS AND OPERATIONS (Indicate approximate year)

CHECK IF YOU HAVE HAD A BAD REACTION TO ANESTHESIA? ☐ YES ☐ NO

HAS A BLOOD RELATIVE HAD A BAD REACTION TO ANESTHESIA? ☐ YES ☐ NO

HEALTH HISTORY

YES	NO	HAVE YOU EVER HAD:
		DIABETES CONTROLLED BY DIET PILLS INSULIN BLOOD SUGAR RESULTS
		HYPOGLYCEMIA (Low blood sugar)
		THYROID PROBLEMS
		HEART PROBLEMS (Rheumatic Fever, Murmur, Chest Pain, Heart Attack, Irregular Heartbeat, EKG changes, Angina, Valve Replacement, Pacemaker, Heart Failure, etc.)
		BLOOD CLOTS, TRANSFUSION PROBLEMS, OR BLEEDING TENDENCY (Hemophilia, Anemia, Sickle Cell, etc.)
		HIGH BLOOD PRESSURE
		STROKE (Weakness/Numbness on one side, Difficulty Speaking, Loss of Vision, etc.)
		SEIZURES (Epilepsy, Convulsions, Blackouts, etc.)
		NEUROLOGICAL PROBLEMS (Loss of Sensation, Numbness, Tingling, etc.)
		SEVERE HEADACHES
		LUNG PROBLEMS (Asthma, Chronic Cough, Pneumonia, Wheezing, Shortness of Breath, Emphysema, Abnormal Chest X-ray, Oxygen, etc.)
		TUBERCULOSIS/TB
		SLEEP APNEA (Breathing Interruption During Sleep, CPAP, etc.)
		LIVER PROBLEMS (Jaundice, Hepatitis, etc.)
		KIDNEY, BLADDER, OR PROSTATE PROBLEMS (Infections, etc.)
		STOMACH PROBLEMS (Ulcer, hiatal hernia, reflux, heartburn, nausea/vomiting, etc.)
		BOWEL PROBLEMS (Irritable Bowel, Diverticulosis, Diarrhea, etc.)
		BACK TROUBLE (Disc Problems, Numbness/Tingling of Hands or Feet, etc.)
		BROKEN BONES OF HEAD, NECK, OR SPINE OR RESTRICTIONS IN MOVEMENT OR DIFFICULTY OPENING MOUTH (TMJ, etc.)
		ARTHRITIS
		MUSCLE DISORDERS (MD, Myasthenia Gravis, Myositis, MD, etc.)
		CANCER
		MENTAL HEALTH/PHOBIAS (Anxiety, Depression, Psychosis, etc.)
		MENTAL DISABILITY (Confusion, Memory Loss, Downs Syndrome, etc.)
		SKIN PROBLEMS (Eczema, Fragile, Rashes, Skin Breakdown, etc.)
		OTHER MEDICAL PROBLEMS/COMMENTS
		ANY ILLNESS, COLD, COUGH OR FEVER WITHIN THE LAST WEEK?
		RECENT EXPOSURE TO ANY COMMUNICABLE DISEASES? (Chicken Pox, Measles, etc.)
		IF AGE 18 OR OLDER
		Do you have advance directives/living will?________ Did you bring a copy with you?________
		Would you like more information about advanced directives/living will? Information provided by________________________________

YES	NO	
		DO YOU HAVE A HISTORY OF SMOKING? PACKS PER DAY DATE QUIT
		DO YOU DRINK ALCOHOLIC BEVERAGES? HOW OFTEN HOW MUCH
		DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE OR ADDICTION?
		DO YO HAVE ANY OF THE FOLLOWING: ☐ False Teeth ☐ Braces ☐ Jewelry Removed ☐ Loose Teeth ☐ Retainers ☐ Body Piercing ☐ Bridges ☐ Chipped Teeth ☐ Hearing Aids ☐ Capped Teeth ☐ Contact Lenses
		ARE YOU RECEIVING TREATMENT FOR GLAUCOMA?
		DO YOU HAVE ANY SPECIAL NEEDS OR CONCERNS? ☐ Hearing_______ ☐ Speech_______ ☐ Vision_______ ☐ Translator______________________ ☐ Language________ ☐ Learning Needs_________________ ☐ Limitations________
		DO YOU HAVE ANY PHYSICAL LIMITATIONS?
		DO YOU HAVE ANY ENVIRONMENTAL CONCERNS? (Room Temperature, Lighting, etc.) ☐ ________________________________
		DO YOU HAVE ANY SPECIAL REQUESTS?
		DO YOU CURRENTLY NEED ASSISTANCE TO GET AROUND THE HOUSE, DO ERRANDS, AND TAKE CARE OF YOUR PERSONAL NEEDS?
		WOULD YOU LIKE TO DISCUSS ANY CONCERNS OR FEARS REGARDING THIS PROCEDURE?
		WOMEN: IS THERE A POSSIBILITY YOU ARE PREGNANT? LAST MENSTRUAL PERIOD: ARE YOU BREASTFEEDING?
		DATE OF LAST IBUPROFEN, ASPIRIN OR BLOOD THINNERS. DATE: ______________________ LIST: ________________________________
		PATIENT'S OR SIGNIFICANT OTHERS SIGNATURE RELATIONSHIP DATE X
		COMMENTS:
		History Completed ☐ Reviewed by: ☐ RN ________________________________ ☐ CRNA ________________________________ ☐ MD ________________________________

2130-09 (8/31/16)