Patient Health History – Fish Pond Surgery Center

1. Please list any allergies to foods, dyes, or tape/latex and your reaction:

_____

2. Please list all surgeries, procedures, or hospitalizations and dates, if possible:

_____ _____ _____

_____ _____ _____

_____ _____ _____

3. Please check the following that apply:

____Former smoker/tobacco user When did you quit? _____

____Smoke/Use tobacco currently How much per day?_____ Number of years? _____

____Consume alcohol, beer, or wine How much? _____ How often?_____

____History of substance abuse What substance?_____ Last used? _____

4. **CIRCLE** if you have false teeth, loose teeth, caps, bridge work, partial plates, hearing aids, contact lenses

5. **FOR WOMEN ONLY**: Have you had a hysterectomy? YES NO
Start date of last menstrual period_____

6. Have you or a blood relative ever had a problem with general or local anesthesia? YES NO
If yes, check any that apply:

____Jaundice or Hepatitis after anesthesia ____Increased temperature

____Drop or increase in blood pressure ____Nausea or vomiting

____Difficulty "waking up" or difficulty breathing ____Behavior changes upon waking

7. Check if you had or still have any of the following:

____Asthma	____Arthritis	____Diabetes
____Emphysema (COPD)	____Muscle spasms	____Stroke, paralysis, polio
____Tuberculosis (TB)	____Anxiety, depression	____Jaundice, Hepatitis, liver trouble
____Other lung problems_____	____Anemia	____Kidney failure, stones, infection
____High blood pressure	____HIV/AIDS	____Convulsions, Epilepsy, seizures
____Heart attack (When?_____)	____Dizziness	____Heartburn/Reflux
____Chest pain/ Angina	____Numbness	____Stomach ulcers
____Congestive heart failure	____Visual changes	____Broken bone
____Irregular heart beat/Pacemaker	____Headaches	____Cough or fever over the past week
____Other heart problems_____	____Multiple Sclerosis	____Thyroid problems
____Any degenerative muscle disease	____Sleep Apnea / CPAP	____Mental Deficiency

8. Name of your family physician/cardiologist: _____

9. Is there anything pertaining to your medical history that we have not covered? If yes, please explain:

_____

_____

10. Do you have an advance directive? YES NO If yes, please bring with you.

11. Have you made arrangements for transportation and for someone to help you after discharge? YES NO