

PATIENT HISTORY QUESTIONNAIRE**PATIENT INFORMATION**

Patient Name: _____ Date of Birth: _____ Age: _____
 Stated Height: _____ Stated Weight: _____
 Primary Language: _____ Interpreter Needed? ☐ Yes ☐ No For which language? _____
 Telephone #'s: Home () _____ Work () _____ Cell () _____
 Contact Person: _____ Contact Phone Number: () _____

INTERNIST/PRIMARY CARE PHYSICIAN AND VISIT INFORMATION

Internist/PCP: _____ Last Visit: _____ Next Visit: _____ Prior to Surgery? ☐ Yes ☐ No
 Cardiologist: _____ Last Visit: _____ Next Visit: _____ Prior to Surgery? ☐ Yes ☐ No
 Other Specialist: _____ Last Visit: _____ Next Visit: _____ Prior to Surgery? ☐ Yes ☐ No

ALLERGIES AND PREVIOUS SURGERIES

Allergies Title	Reaction

Previous Surgery Details	Surgery Year	Anesthesia Used

Please indicate if you have had any of the following CARDIAC/MEDICAL procedures listed below:

Angioplasty: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No Stent Placed? ☐ Yes ☐ No
 Echocardiogram: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No
 Stress Test: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No
 Pacemaker: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No
 Pacemaker Brand: _____ Pacemaker Model: _____

Other Procedure: _____

CARDIOVASCULAR

- | | | |
|--|--|---|
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Arrhythmias, i.e., A-Fib | <input type="checkbox"/> History of DVT/PE |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Carotid Artery Disease |
| <input type="checkbox"/> Heart Valve Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Pain or shortness of breath when walking
2 blocks or climbing 1 flight of stairs | <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Hypertension |
| | <input type="checkbox"/> Family History of Heart Disease | |

Date of Heart Attack: _____ Date of Chest Pain: _____

PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____

PULMONARY

- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ CPAP
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Tuberculosis

HEMATOLOGIC

- ☐ Anemia
- ☐ Bleeding/Clotting Disorders
- ☐ Blood Transfusions
- ☐ Leukemia/Lymphoma

GASTROINTESTINAL

- ☐ Cirrhosis
- ☐ Digestive Problems
- ☐ Gastric Reflux
- ☐ Hepatitis A, B, or C

NEUROLOGIC

- ☐ Anxiety/Depression/Mood Disorders
- ☐ Dementia
- ☐ Fainting
- ☐ Headache
- ☐ Muscle Weakness
- ☐ Neuromuscular Disorders
- ☐ Numbness
- ☐ Seizures
- ☐ Stroke/Mini Stroke

GENITOURINARY

- ☐ Dialysis
- ☐ Kidney Stones
- ☐ Prostate Disease
- ☐ Urinary Tract Infections

ENDOCRINE

- ☐ Diabetes
- ☐ Hypo/Hyperthyroidism
- ☐ Hypoglycemia
- ☐ Recent Steroid Therapy

PAIN

- ☐ Artificial Joints, Location: _____
- ☐ Back/Neck Pain
- ☐ Chronic Pain Treatment
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis

GENERAL HEALTHCARE

Do you, or have you ever had any of the following?

Cancer:

- Have you had or have cancer? ☐ Yes ☐ No
- Have you had radiation therapy? ☐ Yes ☐ No
- Have you had chemotherapy? ☐ Yes ☐ No
- Where was/is the cancer located? _____

Have you had any of the following vaccines?

Ever taken the flu vaccine? ☐ Yes ☐ No

In what date: _____

Ever taken the pneumonia vaccine? ☐ Yes ☐ No

In what year: _____

For Female Patients:

Any possibility of pregnancy? ☐ Yes ☐ No

Date of last menstrual period? _____

Tell us about your social history:

Smoking History:

Do you smoke? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No

For how many years? _____ Year Quit: _____

Any smoking in the past 12 months? ☐ Yes ☐ No

Alcohol History:

Do you drink alcohol? ☐ Yes ☐ No

How much alcohol do you consume and how often?

Drug History:

Do you use recreational drugs? ☐ Yes ☐ No

What kind of recreational drugs do you use?

Malignant Hyperthermia (MH) History:

Family history of MH? ☐ Yes ☐ No

SURGICAL INFORMATION

Do you exercise? ☐ Yes ☐ No If yes, Type: _____

Do you wear contact lenses? ☐ Yes ☐ No

Do you have caps, bridges, dentures or loose teeth? ☐ Yes ☐ No

SIGNATURES

[Patient/Parent/Conservator/Guardian]

[Date]

[Time]

[If completed by other than patient, indicate relationship]

[Reviewed by Assessment Nurse]

[Date]

[Time]

[Reviewed by Procedure Nurse]

[Date]

[Time]

[Reviewed by PACU Nurse]

[Date]

[Time]

[Reviewed by Discharge Nurse]

[Date]

[Time]