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

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

Date of Heart Attack: __________ Date of Chest Pain: ____________

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]