HEALTH QUESTIONNAIRE

Instructions: Please complete this Health Questionnaire and bring it with you to the hospital.

Name: _____ Height _____ Weight _____Date of Surgery: _____

Allergies to Medications: _____

Allergies to Food/Environmental: _____

				Comments
1.	Have you or family member had a problem with anesthesia?	☐ No	☐ Yes	_____
2.	Do you smoke or ever smoked, when did you quit ? If so, how many packs per day?	☐ No	☐ Yes	_____
3.	Do you drink alcohol? If so how much?	☐ No	☐ Yes	_____
4.	Do you have chipped or loose teeth? Dentures?	☐ No	☐ Yes	_____
5.	Do you feel you bleed or bruise easily?	☐ No	☐ Yes	_____
6.	Are you on blood thinners?	☐ No	☐ Yes	_____
7.	Do you have a cold or are you recovering from one?	☐ No	☐ Yes	_____
8.	Do you have a history of blood clots?	☐ No	☐ Yes	_____
9.	Do you have pain? Where? _____	☐ No	☐ Yes	_____

Have you ever had:

10.	To stay over night in the hospital?	☐ No	☐ Yes	_____
11.	Epilepsy/Seizures?	☐ No	☐ Yes	_____
12.	Diabetes?	☐ No	☐ Yes	_____
13.	Lung Disease (e.g. emphysema, pneumonia, etc.)?	☐ No	☐ Yes	_____
14.	Asthma? Date of last attack _____	☐ No	☐ Yes	_____
15.	Sleep Apnea?	☐ No	☐ Yes	_____
16.	Cancer?	☐ No	☐ Yes	_____
17.	Stroke?	☐ No	☐ Yes	_____
18.	Heart Problems (e.g. heart failure, Irregular beats, etc.)? Cardiologist _____	☐ No	☐ Yes	_____
19.	Pacemaker? AICD? If yes, name of company? _____	☐ No	☐ Yes	_____
20.	High blood pressure?	☐ No	☐ Yes	_____
21.	Liver problems (e.g. hepatitis, cirrhosis)?	☐ No	☐ Yes	_____
22.	Kidney or urinary problems (e.g. kidney failure or stones, enlarged prostate)?	☐ No	☐ Yes	_____
23.	Could you be pregnant? Date last menstrual period: _____	☐ No	☐ Yes	_____
	Pregnancy test refused: ☐ Signature _____	☐ No	☐ Yes	_____
24.	Stomach problems (e.g. acid reflux, ulcers, etc.)	☐ No	☐ Yes	_____
25.	Bowel Problems (e.g. constipation, irritable bowel, etc.)	☐ No	☐ Yes	_____
26.	Emotional Problems (anxiety, depression, bipolar, etc.)	☐ No	☐ Yes	_____
27.	Dizzy spells/fainting?	☐ No	☐ Yes	_____

List all operations you have had: **Date or Age at Operation**

_____

_____

_____

_____

Who will take you home after your procedure?

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

(See other side of page) →

Home Medications (Include prescription, non- prescription, herbal and vitamin supplements)			
Medication Name	**Dose**	**Route**	**Frequency**

Would you accept a blood transfusion if medically necessary?_____

Nutritional Services Screen: Are you currently on a special diet? _____

Exercise screen: What kind of exercise do you do? _____

Have you had a flu vaccine in the past year? ☐ No ☐ Yes Date: _____
Have you had a pneumococcal vaccine within the last 5 years? ☐ No ☐ Yes Date: _____
Year of last tetanus vaccine: _____ Year of TB skin test? _____ ☐ Positive ☐ Negative
Do you have a history of infectious disease (MRSA, TB, Hepatitis) _____

Do you have an Advance Directive? ☐ No ☐ Yes
☐ Living Will ☐ Medical durable power of attorney ☐ Other _____
Does the hospital have a copy? ☐ No ☐ Yes

Do you have thoughts of harming yourself or others ☐ No ☐ Yes
Do you have a history of substance abuse (drugs/Alcohol) ☐ No ☐ Yes Date of last use? _____
Do you live in a safe environment?_____

Form Completed by: _____ **Date:** _____

Reviewed by: _____ **RN Date:** _____ **Time:** _____

PATIENT ID