

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:

<input type="checkbox"/> Former smoker/tobacco user	When did you quit? _____	
<input type="checkbox"/> Smoke/Use tobacco currently	How much per day? _____	Number of years? _____
<input type="checkbox"/> Consume alcohol, beer, or wine	How much? _____	How often? _____
<input type="checkbox"/> 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:

<input type="checkbox"/> Jaundice or Hepatitis after anesthesia	<input type="checkbox"/> Increased temperature
<input type="checkbox"/> Drop or increase in blood pressure	<input type="checkbox"/> Nausea or vomiting
<input type="checkbox"/> Difficulty "waking up" or difficulty breathing	<input type="checkbox"/> Behavior changes upon waking

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

<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Emphysema (COPD)	<input type="checkbox"/> Muscle spasms	<input type="checkbox"/> Stroke, paralysis, polio
<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Anxiety, depression	<input type="checkbox"/> Jaundice, Hepatitis, liver trouble
<input type="checkbox"/> Other lung problems _____	<input type="checkbox"/> Anemia	<input type="checkbox"/> Kidney failure, stones, infection
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Convulsions, Epilepsy, seizures
<input type="checkbox"/> Heart attack (When? _____)	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Heartburn/Reflux
<input type="checkbox"/> Chest pain/ Angina	<input type="checkbox"/> Numbness	<input type="checkbox"/> Stomach ulcers
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Visual changes	<input type="checkbox"/> Broken bone
<input type="checkbox"/> Irregular heart beat/Pacemaker	<input type="checkbox"/> Headaches	<input type="checkbox"/> Cough or fever over the past week
<input type="checkbox"/> Other heart problems _____	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Any degenerative muscle disease	<input type="checkbox"/> Sleep Apnea / CPAP	<input type="checkbox"/> 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