TRI·COUNTY SURGERY CENTER

Health History Questionnaire

Patient label to be attached by Center

Dear Patient:

We welcome the opportunity to participate in your care. Patients requiring the services of an anesthetist will be seen personally prior to surgery. This Health Survey allows us to identify patients who may need specialized instructions. We depend on this Survey, along with information provided by your surgeon and your primary care physician, to develop a plan for your care. Please complete all sections of this Survey to the best of your ability.

Patient Name:		Primary Physician:
Home Phone:	Work/ Cell Phone:	HT: WT: Age:

	YES	NO	COMMENTS
• Are you being treated for any medical problems?			______
• Do you have high blood pressure?			______
• Do you have heart trouble?			______
• Do you have a heart murmur?			______
• Do you have angina or chest pain?			______
• Have you had a heart attack?			______
• Have you had a cold recently?			______
• Do you have a cough?			______
• Have you had asthma?			______
• Do you have emphysema or bronchitis?			______
• Do you get short of breath walking up a flight of stairs?			______
• Do you have diabetes?			______
• Do you have a seizure disorder?			______
• Do you have a weakness of or paralysis of your arms or legs?			______
• Have you had a stroke?			______
• Have you had hepatitis or jaundice?			______
• Do you take a blood thinner?			______

	YES	NO	COMMENTS
• Do you have psychiatric problems?			______________________________
• Could you be pregnant?			______________________________
• Have you had anesthesia previously?			______________________________
• Have you ever had a problem with anesthesia other than nausea or vomiting?			______________________________
• Has anyone in your family had a problem with anesthesia?			______________________________
• Do you smoke presently? If so, how much?			______________________________
• Do you drink alcohol? If so, how much?			______________________________
• Do you have a history of using Flomax medication?			______________________________
• Do you have any surgical implants?			______________________________
• Have you ever been treated for MRSA? **If yes, When**?			______________________________

	YES	NO	REACTION
• Do you have a LATEX (balloons, gloves, etc) allergy?			______________________________
• Do you have an IODINE (IV dye, etc) allergy?			______________________________

List all medications you are presently taking **on the separate Medication Reconciliation Form**

List all previous surgery: ____

____

____

List all drug allergies and reaction ie: hives, difficulty breathing, etc. to each specific drug: ________________

____

List all food allergies and reactions: ____

Do you have anything specific you want to discuss with the anesthetist (Not Applicable for Laser Procedures)?

____

____

____________________ Patient Signature	________ Date	**CHANGES**	**YES**	**NO**	**IF YES, WHAT?**
____________________ Patient Signature (for update only)	________ Date				______________
____________________ Patient Signature (for update only)	________ Date				______________
____________________ Patient Signature (for update only)	________ Date				______________
____________________ Patient Signature (for update only)	________ Date				______________