SageWest HEALTH CARE

PHONE NUMBER THAT WE CAN CONTACT YOU AT FOR PREOP: _____

Health History Questionnaire

Do You Have Currently or Have You Ever Been Treated For:

~~(PLEASE TURN OVER AND COMPLETE BACK PAGE)~~

		Yes	No
CARDIOVASCULAR	Heart Attack, Angina, or Chest Pain	☐	☐
	Heart Murmur or Rheumatic Fever	☐	☐
	Varicose Veins	☐	☐
	History of Blood Clot or Pulmonary Embolism	☐	☐
	Swelling of Ankles or Circulation Problems	☐	☐
	Irregular Heart Beat	☐	☐
	Blood Pressure: ☐High ☐Low		
	EKG Done in the Last 3 Months	☐	☐
	Date: Location/Doctor:		
	Pacemaker/Implated Defribrillator	☐	☐
	Brand: Doctor/Hospital:		
	Comments:		
RESPIRATORY	Asthma, Emphysema, COPD or Wheezing	☐	☐
	Bronchitis or Pneumonia	☐	☐
	Tuberculosis	☐	☐
	Shortness of Breath, Cough, or Cold NOW	☐	☐
	Oxygen Used at Home	☐	☐
	Sleep Apnea	☐	☐
	C-PAP or Bi-PAP Used at Home	☐	☐
	Comments:		
GASTROINTESTINAL/URINARY/REPRODUCTIVE	Bowel Problems/Change in Bowel Habits	☐	☐
	Heartburn/Acid Reflux	☐	☐
	Ulcers	☐	☐
	Hiatal Hernia	☐	☐
	Ostomy	☐	☐
	Recent Weight Loss or Gain (circle one)	☐	☐
	# Pounds: Length of Time:		
	Difficulty with Chewing or Swallowing	☐	☐
	Jaundice	☐	☐
	Hepatitis	☐	☐
	Other:		
	Urinary or Kidney Problems	☐	☐
	Foley Catheter (Date Inserted? _____)	☐	☐
	Female: Date of Last Menstrual Period:		
	Are You Pregnant?	☐	☐
	Are You Breast Feeding?	☐	☐
	Comments:		
IMMUNE SYSTEM	Flu Vaccine: If Yes, When?	☐	☐
	Pneumovax: If Yes, When?	☐	☐
	Have You Been Out of the Country		
	in the Last 30 Days?	☐	☐
	Have You Been Around Anyone Who Has?	☐	☐
	If Under Age 20:		
	Are Immunizations Current?	☐	☐
	Do You Currently Have an Infectious Disease?	☐	☐
	If Yes, Explain:		

		Yes	No
NEUROLOGICAL	Head Injury	☐	☐
	Epilepsy, Seizures, or Convulsions	☐	☐
	Weakness, Tingling, Numbness	☐	☐
	Blackout Spells	☐	☐
	Stroke	☐	☐
	Paralysis	☐	☐
	Severe Headache or Migraines	☐	☐
	Nervous Disorder or Mental Illness	☐	☐
	Depression or Anxiety	☐	☐
	Comments:		
MUSCULOSKELETAL	Muscle or Joint Pain	☐	☐
	Back or Neck Problem	☐	☐
	Arthritis or Gout	☐	☐
	Amputation	☐	☐
	Total Joint Replacement Where:	☐	☐
	Metal Plate/Pins/Screws Where:	☐	☐
	Comments:		
ENDOCRINE	Thyroid Disease	☐	☐
	Diabetes:	☐	☐
	Diet Controlled	☐	☐
	Oral Medications	☐	☐
	Insulin:	☐	☐
	Type: Dosage:		
	Hypoglycemia	☐	☐
	Steroid or Cortisone in the Last Year	☐	☐
	When: Why:		
	Comments:		
ALLERGIES / MISC.	Are You Allergic to Anything	☐	☐
	If Yes, Please List on Back of Sheet		
	Do You Have a Venous Access Device/Port	☐	☐
	Have You Ever had a Blood Transfusion	☐	☐
	Did You Have a Reaction?	☐	☐
	Do You Have Prologned Bleeding or Bruise Easily	☐	☐
	Do You Regularly Take Coumadin, Aspirin, Ibuprofen	☐	☐
	How Much: How Often:		
	Do You Have a Blood Disorder	☐	☐
	Anemia, Leukemia, Immunodeficiency	☐	☐
	HIV or AIDS	☐	☐
	Cancer: Type:	☐	☐
	Treatment:		
	In Remission:	☐	☐
	Have You or Any Blood Relative Ever Had Difficulty		
	with Local or General Anesthetic	☐	☐
	If Yes, Explain:		
	Current Height:		
	Current Weight:		

What Procedure are You Having Done?

Why are You Having this Procedure?

How Long Has this been Going On?

Who is the Surgeon Doing This Procedure?

Do You Use Tobacco? Yes No

Type & Amount

How Long

Do You Use Alcohol? Yes No

Type & Amount

Do You Use Recreational or Addicting Drugs? Yes No

Type & Amount

Do You Live with:

- ☐ Spouse or Significant Other
- ☐ Parents
- ☐ Extended Family
- ☐ Alone
- ☐ Other:

Name of Adult Who will Drive You Home

Do You Have Someone to Assist at Home Yes No

Do You Feel Safe in Your Home Environment Yes No

Primary Language

Preferred Language

Grade Completed in School

Can You Read & Write Yes No

Preferred Learning Style

- ☐ Demonstration with Return Demonstration
- ☐ Teach Back (Return Verbalization of Instructions)
- ☐ Listening and Discussing
- ☐ Reading
- ☐ Video
- ☐ Other:

Current Diet

- ☐ Normal
- ☐ Nothing by Mouth after Midnight (NPO)
- ☐ Clear Liquid
- ☐ Caffeine (Coffee, Tea, Cola, etc.)
- ☐ Other:

Name of Pharmacy:

ADLs / Self Care

- ☐ **Normal Vision**
  - ☐ Glasses
  - ☐ Contact Lenses
  - ☐ Glaucoma
- ☐ **Normal Hearing**
  - ☐ Hearing Aid
  - ☐ Deaf
  - ☐ Decreased Hearing
- ☐ **Normal Speech**
- ☐ **Normal Teeth**
  - ☐ Dentures
  - ☐ Partial Plate
  - ☐ Bridges
  - ☐ Loose Teeth
- ☐ **Normal Mobility**
  - ☐ Crutches
  - ☐ Walker
  - ☐ Wheelchair
  - ☐ Unable to Walk

Need Assistance With:

- ☐ Dressing
- ☐ Transferring
- ☐ Walking
- ☐ Sitting
- ☐ **Skin Intact**
  - ☐ Rashes
  - ☐ Bruises
  - ☐ Sores

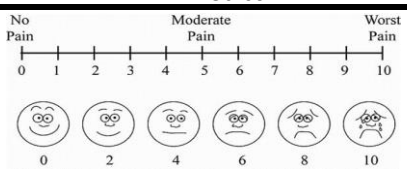
Pain:

Location:

Does it Move? Yes No

Where:

Pain Scale (0-10)



☐Constant ☐Comes and Goes ☐Only with Movement

What Makes it Better:

What Makes it Worse:

Description/Quality:

- ☐ Achy ☐ Numb ☐ Tiring
- ☐ Tender ☐ Gnawing ☐ Throbbing
- ☐ Sore ☐ Penetrating ☐ Burning
- ☐ Dull ☐ Squeezing ☐ Deep
- ☐ Shooting ☐ Stabbing ☐ Pressure
- ☐ Crampy ☐ Sharp ☐ Other:

Previous Surgeries with Dates:

Prescriptions/Herbal/Supplements/Over the Counter Medications:

CAN PROVIDE A HAND WRITTEN LIST OR COPY FROM PHARMACY. MAKE SURE TO INCLUDE DOSE AND HOW OFTEN.

Name:	Strength:	Route:	How Often:	Last Dose Taken:

Allergies/Reactions: