

**PATIENT HISTORY QUESTIONNAIRE**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Stated Height: \_\_\_\_\_ Stated Weight: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Telephone Numbers: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_  
 Procedure: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_  
 Physician performing procedure: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
 Internist: \_\_\_\_\_ Last seen: \_\_\_\_\_ Cardiologist: \_\_\_\_\_ Last seen: \_\_\_\_\_

**ALLERGIES and ALLERGY REACTIONS:**

**LIST PREVIOUS SURGERIES:**      Year      Complications      Type of Anesthesia

**LIST PREVIOUS CARDIAC/MEDICAL PROCEDURES:**      angioplasty/stent placement, echocardiogram, stress test,  
 Procedure      Year      pacemaker or defibrillator model/brand #, and where done

Please check appropriate box in each section below:

<b>CARDIOVASCULAR</b>	Yes	No		Yes	No
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack – Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	Pain or shortness of breath when walking 2 blocks or climbing 1 flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation in lower extremities	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease (age of onset)	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmias i.e. A-Fib	<input type="checkbox"/>	<input type="checkbox"/>	Father      Mother      Siblings		
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____      _____      _____		
Heart Valve problems	<input type="checkbox"/>	<input type="checkbox"/>			
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>			
Carotid Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>			

<b>PULMONARY</b>	Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots in lungs or legs	<input type="checkbox"/>	<input type="checkbox"/>
COPD/Bronchitis/Emphysema (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Oxygen Use	<input type="checkbox"/>	<input type="checkbox"/>

**PATIENT HISTORY QUESTIONNAIRE**

PS 2999

Rev 03/21/06

Side 1 of 2

Addressograph



[1508]

<p><b>GASTROINTESTINAL</b></p> <p>Hiatal Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ulcers/GERD/Gastric Reflux (circle) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gallstones <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis A, B or C <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>GENITOURINARY</b></p> <p>Urinary Tract Infections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Stones <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prostate Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penile Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>HEMATOLOGIC</b></p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood Diseases i.e. Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood Transfusions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Easy Bruising <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>ENDOCRINE</b></p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hypo/Hyperthyroidism <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>NEUROLOGIC</b></p> <p>Stroke/TIA's <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Myasthenia Gravis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Muscle Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Headache <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Numbness <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>PAIN</b></p> <p>Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Osteoarthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chronic Pain Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Back/Neck Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Location: _____</p>
<p><b>GENERAL HEALTHCARE</b></p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Location: _____</p> <p>Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Immune Deficiency <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Measles/Mumps/Rubella (circle) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you had:</p> <p>MMR Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Flu Vaccine – Date: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pneumonia Vaccine – Year: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>TB Skin Test <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown</p>	<p><b>Social History:</b></p> <p>Do you drink alcohol? Amount: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Did you ever smoke? Years: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you smoked in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Type: _____</p> <p><b>If female: possibility of pregnancy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Last menstrual period:</b> _____</p> <p>History of Malignant Hyperthermia (MH) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Family history of anesthesia problems or MH (circle) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>SURGICAL INFORMATION</b></p> <p>Do you have any specific needs?</p> <p>Hearing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Living alone <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Transportation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Type: _____</p>	<p>Do you need information on:</p> <p>Current surgery <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Medications <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Activities <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Home Care <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have caps, bridges, dentures or loose teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

\_\_\_\_\_  
[Patient/Parent/Conservator/Guardian]

\_\_\_\_\_  
[If completed by other than patient, indicate relationship]

\_\_\_\_\_  
[Date]

**THIS SECTION FOR HOAG FACILITY PERSONNEL USE ONLY**

\_\_\_\_\_  
[Reviewed by Assessment Nurse]

\_\_\_\_\_  
[Date]

\_\_\_\_\_  
[Time]

\_\_\_\_\_  
[Reviewed by Procedure Nurse]

\_\_\_\_\_  
[Date]

\_\_\_\_\_  
[Time]

\_\_\_\_\_  
[Reviewed by PACU Nurse]

\_\_\_\_\_  
[Date]

\_\_\_\_\_  
[Time]

\_\_\_\_\_  
[Reviewed by Discharge Nurse]

\_\_\_\_\_  
[Date]

\_\_\_\_\_  
[Time]