



TO REMOVE TEAR ALONG DOTTED LINE

Procedure/Surgery Patient Health Information

Please complete the Patient Health Information form (two pages, front and back). If you have had surgery at Doctors Community Hospital within the last three months, you do not need to complete another form; however, we do need you to identify any changes that have occurred in your health status since your last visit.

Please remember to bring any required X-rays or mammograms with you on the day of your surgery.

Name _____	Age _____	Height _____	Weight _____
Primary Doctor _____	Phone _____	Today's date _____	
Surgeon _____	Date of procedure _____		

Do you/have you had any of the following?	Yes	No	Comments
Central Nervous System			
CVA (stroke)/TIA			
Seizures			
Depression/anxiety/panic attacks			
History of mental illness			

Cardiovascular System			
Pacemaker/defibrillator (ICD)			
Coronary artery disease/cardiac stents			
Heart attack			
Heart surgery			
Heart valve disease/ heart murmur/irregular heart beat			
Antibiotics before dental work			
Hypertension/high blood pressure			
Blood clot in leg or lung			
Peripheral vascular disease/circulation problems			
Elevated cholesterol			
Shortness of breath or recent chest pain			
Congestive heart failure			
Have you ever seen a heart doctor/cardiologist?			

Do you/have you had any of the following?	Yes	No	Comments
Respiratory System			
Asthma			Last attack
COPD/ emphysema			
Present cold/cough/fever/sinus trouble			
TB			
Sleep apnea			CPAP? <input type="checkbox"/> Yes <input type="checkbox"/> No
Smoking			<input type="checkbox"/> # packs/day <input type="checkbox"/> # years quit date

Gastrointestinal System			
Irritable Bowel Syndrome or Crohns			
Hepatitis			Type of hepatitis
Hiatal hernia			
Reflux/heartburn			
Ulcer disease			
Alcohol use			How much?
			How often? How long?

Renal (Kidney) System			
Renal failure			
Kidney stones/blood in urine			
Enlarged prostate			
Urinary tract infection (UTI)			
Dialysis			Type?
			Days of week? Access location?

Endocrine System			
Diabetes			
Thyroid problems			

Hematologic (Blood) System			
Anemia			
Sickle cell anemia/trait			
Cancer/tumor			When diagnosed: Location:
Cancer treatment			Type?
Blood and/or blood product transfusion			
Bleeding/platelet disorder			

Do you/have you had any of the following?	Yes	No	Comments
Pain			
Arthritis/location(s)			
Neck/jaw or back problems			
Pain occurring daily/location of pain			
Do you use a walker or cane/wheelchair?			

Immune System			
HIV			
Lupus/sarcoidosis			
Rheumatoid arthritis			
Recent use of prescribed steroids			Date?

Skin Integrity			
Do you have any sores, ulcers, blisters or rashes?			If yes, where?

Other			
Do you wear glasses or contacts?			Describe
Do you have dentures, bridges, braces or crowns?			Describe
Do you have any artificial limbs?			Describe

Please list prescription medications. Include drug name, dose and how often taken, including all medications, herbals, over the counter medications and diet pills.

Drug name	Dose	How often

Have you taken aspirin and/or non-steroidal medication (Ibuprofen, Excedrin, Motrin/Aleve, Advil) within the last week?

No Yes (please list) _____

Do you use recreational drugs?

No Yes (please list) Type _____ Last use _____

Do you have any allergies, sensitivities to drugs, foods, environment, latex or rubber products?

No Yes (please list) _____

Do you have any retained hardware (plates/screws/artificial joints)?

No Yes (please list location and type) _____

Do you have any body piercing (other than ears)?

No Yes (if yes, please list location[s]) _____

Please list any major surgeries or hospitalizations, include date of procedure

Do you have any problems with anesthesia medications?

No Yes (if yes, please describe) _____

Do you have any family history of anesthesia problems?

No Yes (if yes, please describe) _____

Are you a Jehovah's Witness? No Yes

Are you an organ donor? No Yes

Do you have an Advanced Directive or Durable Power of Attorney?

No Yes (please bring a copy on day of surgery)

Patient signature _____ Date _____

Patient representative signature _____ Relationship to patient _____

Updated by PRE-OP RN _____ Date _____

APEC RN _____ Date _____

DAY OF PROCEDURE, PRE-OPERATIVE SECTION:

Patient signature _____ Date _____

Patient representative signature _____ Relationship to patient _____

PRE-OP RN _____ Date _____