HEALTH HISTORY QUESTIONNAIRE

Name: ________________________ **M/F** Age:____ Wt:____ Ht:_____

Do you wear? *(Circle one)*
Contacts: Y N **Dentures:** Y N **Hearing Aids**: Y N Left/Right/Both

Allergies to Medications, Foods, Tape, LATEX, etc.: ___________________________________
(Please list)

Who will take you home? ________________Relationship:_____________ Phone#___________

Current Medications (Prescription/Over-the-Counter/Herbal)– *(please attach list if necessary)*

Medication	Dose/Mg	X per day	Medication	Dose/Mg	X per day
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Have you or a blood relative ever had a complication with anesthesia? ☐ Yes ☐ No
If yes, describe____

Previous Surgeries/dates ____

Medical History *(Check all that apply to you)*

Cardiac	Lungs	Thyroid
☐ Angina/Chest Pain ☐ Congestive Heart Failure ☐ Irreg. Heart Beats/A-Fib ☐ Coronary Bypass #___ ☐ High Blood Pressure ☐ Pacemaker/AICD	☐ Asthma/Use Inhalers ☐ Emphysema ☐ COPD/Use Oxygen at home? ☐ Bronchitis ☐ Allergies ☐ Sleep Apnea/Wear CPAP? ☐ Smoker, # Packs per Day	☐ Hyperthyroid ☐ Hypothyroid **Eyes** ☐ Glaucoma ☐ Cataract surgery ☐ Retina surgery
Kidney ☐ Chronic Urinary Tract Inf. ☐ Dialysis, When_________ ☐ Voiding at Night #______	**Liver** ☐ Hepatitis A,B,or C ☐ Cirrhosis ☐ Reflux ☐ Frequent Heartburn	**Diabetics** ☐ Oral Meds ☐ Insulin Reg/NPH ☐ Diet Controlled
Central Nervous System ☐ Stroke/TIA's ☐ Seizures/Migraines **Pregnancy Screen** ☐ Possibility that you might be pregnant? If yes, please speak with your surgeon	**Other** ☐ Alcohol Use - How Often________ ☐ Drug Use - Specify_____________ ☐ Bleeding Disorders ☐ History of Mental Illness ☐ Active Infection (MRSA, TB, etc) ☐ HIV/AIDS ☐ **Take/Have taken FLOMAX**	**PATIENT STICKER**

Patient/Guardian Signature:_____________________________________ **Date:**_____________

There have been no changes to the above: ____________________________ ______________
Patient Signature Date