

LAUREL SURGICAL CENTER
PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ Age: _____ Height: _____ Weight: _____

Date of Procedure: _____ Procedure/ Reason for Visit: _____

Home Phone Number: _____ Family Doctor: _____

Have you ever been a patient at Laurel Surgical Center? Yes No When? _____

Allergies: List all medication, food, dye or Iodine allergies. _____

Are you allergic to Latex? Yes No

Do you have a pacemaker or AICD? Yes No

Past Surgery: List surgery and approximate date.

Medications: List names and dosages of all current medications, including over-the-counter and herbal.

Anesthesia: Have you ever had an anesthetic? Yes No

Describe any problems you have had with anesthesia.

Have you recently discontinued any medication? If so, list name and dosage.

Describe any family problems with anesthesia.

Do you smoke? Yes No How much? _____ For how long? _____

Do you drink alcohol? No Yes How much? _____

<u>Illnesses:</u>	Yes	No		Yes	No
Bronchitis, cough	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/ Angina	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>

Are you, or could you be, pregnant? Yes No

Is your injury due to an accident or fall? No Yes Date: _____ Place: _____

Please describe in detail: _____

Patient Signature: _____ Date: _____

Reviewed by Nursing: _____ Date: _____