SOUTHWEST WASHINGTON REGIONAL SURGERY CENTER

PATIENT HISTORY QUESTIONNAIRE

Your health and well-being are our primary concern. Your answers to these questions will provide important information to the physicians and nurses who will be caring for you

Name:

Approx. Weight: Approx. Height:

MEDICAL HISTORY INFORMATION

Yes	No	If yes, please circle or explain
☐	☐	Previous surgery or anesthesia
☐	☐	Bad reaction to anesthesia
☐	☐	Relative with bad reaction to anesthesia (e.g. malignant hyperthermia)
☐	☐	History of motion/car sickness
☐	☐	Previous blood transfusion/reaction
☐	☐	Recent infection (cold, flu, communicable disease)
☐	☐	Neurologic problems (seizure, stroke, numbness, weakness)
☐	☐	Migraines
☐	☐	High blood pressure
☐	☐	Heart problems (abnormal rhythm or EKG)
☐	☐	Breathing problems (asthma, shortness of breath, emphysema, abnormal chest x-ray)
☐	☐	Sleep Apnea
☐	☐	Stomach or intestinal problems (heartburn, reflux, ulcers, hiatal hernia)
☐	☐	Liver problems (jaundice, hepatitis)
☐	☐	Kidney problems (bladder/prostate, dialysis shunt)
☐	☐	Back problems
☐	☐	Joint problems/artificial joints, prosthesis/hardware, mobility problems
☐	☐	Skin lesions/wounds/Rashes/Infections
☐	☐	Diabetes (if yes, Insulin____Diet____Oral Agent____)
☐	☐	Thyroid
☐	☐	Bleeding problems/Anemia
☐	☐	Mental health (depression, anxiety, bi-polar, schizophrenia
☐	☐	Post Traumatic Stress Syndrome
☐	☐	I have an Advanced Directive
☐	☐	Previous Surgeries/Other medical information

Medication you currently take (Include over-the-counter medications)	**Taken today?**

Herbal supplements you currently take	**Taken today?**

Medication Allergies

Medication	Reaction

Iodine or shellfish allergy: ☐ Yes ☐ No

Latex Allergy: ☐ Yes ☐ No

- ☐ History of allergic reaction to rubber products
- ☐ History of unexplained allergic reaction in a medical facility
- ☐ Allergy to avocados, bananas, pears or chestnuts

Food/other allergies:

Yes	No	
☐	☐	Smoke? Pack per day_______X______yrs
☐	☐	Drink alcohol (more than occasionally) Last drink__________________
☐	☐	Use recreational drugs? Steroids/Cortisone use in last year?
☐	☐	Immunziations up to date? If patient is under 18, please bring a copy of immunization records.

Religious Preference____________________________

Primary physician________________________________

For Female Patient:

Pregnant/LMP_____________ Mastectomy R L

Nursing_____________________________

Reviewed by/RN Signature:

Patient Name:	
DOB:	
Surgery Date:	
Surgeon:	

PATIENT AUTHORIZATION AND INSTRUCTIONS

1. I HAVE READ AND FULLY UNDERSTOOD THE SURGICAL INSTRUCTIONS AND HAVE ARRANGED FOR ONE RESPONSIBLE PERSON TO ACCOMPANY ME TO THE SURGERY CENTER AND HOME AFTER DISCHARGE. (You should plan to have someone with you overnight following any surgery which requires general anesthesia.)
   Name of responsible person and telephone number:

   ____

2. I certify that the information provided on the Patient Medical History Questionnaire is correct to the best of my knowledge.
3. I understand that I am to have nothing by mouth (this includes water) for eight (8) hours before my scheduled surgery time. Children less than one (1) year of age may have milk or formula up to eight (8) hours before their scheduled surgery time and water up to four (4) hours before surgery. (Patients not receiving IV sedation or anesthesia have no dietary restrictions.)
4. I will notify my doctor immediately if any unusual bleeding, respiratory problems or acute pain occurs after my discharge from the surgery center.
5. I understand that driving a car, operating any machinery or power tools, and signing important papers are unsafe and should not be attempted for twenty four (24) hours after general anesthesia.
6. I understand that ingestion of alcohol is not recommended for twenty four (24) hours after general anesthesia.
7. I also understand that if a condition arises during my stay and the physician feels that admission to the hospital is best for my recovery, then I will be admitted.
8.

X____
Patient Signature Date

X____
Guardian Signature Date

X____
Witness Date

There have been no changes in my medications, allergies or history.

X____
Patient Signature Date

X____
Guardian Signature Date

X____
Witness Date

Patient Name:	
DOB:	
Surgery Date:	
Surgeon:	