

# Patient Health Survey

Anything marked "Yes" should be further explained, including the dates involved, in the comment space provided with each question. We urge you to answer these questions carefully and thoughtfully. Please complete the form at a time when you are free of distractions. Decisions regarding your care will be made from the information provided by you.

Name \_\_\_\_\_ Date \_\_\_\_\_

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Age \_\_\_\_\_

LIST ALL ALLERGIES:

LIST ALL MEDICATIONS TAKEN ON A ROUTINE BASIS:

PLACE "X" IN PROPER COLUMN	YES	NO	COMMENTS
Do you have to take antibiotics to protect your heart for surgery?			
Do you smoke cigarettes?			
Do you drink alcoholic beverages? How many ounces daily?			
Have you ever had any heart problems?	High Blood Pressure		
	Rheumatic Fever		
	Heart Attack		
Is there a family history of heart disease? Yes    No	Chest Pains		
	Irregular Heart Beat		
Have you ever had any lung problems?	Asthma, Hay fever		
	Wheezing, Coughing		
	Pneumonia		
Have you ever had any digestive tract problems?	Ulcers		
	Heart Burn		
	Jaundice/Hepatitis		
Have you ever had any musculo-skeletal problems?	Arthritis		
	Trouble Opening Mouth		
Have you ever had any neurological problems?	Stroke		
	Seizure Disorder		
	Head Injury		
	Fainting		
	Headaches		
	Numbness/Tingling in Extermitities		
Have you ever had any metabolic problems?	Diabetes		
	Thyroid Disease		
Have you ever had any hematologic problems?	Bleeding Tendency		
	Anemia		
	Sickle Cell Disease		
	Easy Bruisability		
	Family History of Bleeding Problems		
Have you ever been treated for nervous or emotional problems?	Depression		
	Other		

Year	Operation	Type of Anesthesia			Complications
		Local	Regional	General	