Providence HEALTH CARE

☐ Mount Saint Joseph Hospital
☐ St. Paul's Hospital

HEALTH HISTORY – PATIENT QUESTIONNAIRE

Patient Name: _____ ☐ Male ☐ Female Phone Number: _____

Birth Date: _____ Height: _____ Weight: _____ Alt. Phone Number: _____

Do you have or have you ever had any of the following?

☐ I have had **problems** with local freezing (anesthetic) or general anesthetic (specify) _____
☐ A blood relative of mine has had **problems** with local freezing (anesthetic) or general anesthetic (specify) _____
☐ I have trouble or difficulty opening my mouth or moving my neck
☐ I have been a smoker for _____ years How many cigarettes a day? _____
☐ I drink alcohol How much do you drink in a week? _____
☐ I use street drugs Types: _____
☐ I am pregnant or could be pregnant Due Date: _____ or Date of last menstrual period: _____
☐ I have general body pain ☐ I have ongoing pain Where? _____
☐ I am HIV positive

Tell Us About Your Medical History

HEART

☐ Chest Pain or Angina How often: _____ Last date: _____
☐ Heart Attack(s) Date of most recent: _____
☐ High Blood Pressure for _____ years ☐ Congestive Heart Failure for _____ years
☐ Irregular Heart Beat, Palpitations ☐ Abnormal ECG/Heart Tracing
☐ Heart Murmur, Valve Problems, Leaky Valve ☐ Pacemaker Date: _____
☐ Heart Surgery or Bypass Surgery Date: _____ ☐ Angioplasty Date: _____
☐ Automatic Implantable Cardioverter Defibrillator (AICD) Date: _____

BREATHING

☐ I have been admitted to the hospital within the last 6 months with shortness of breath
☐ I have Asthma ☐ Only happens when I exercise or from environmental triggers
☐ I use puffers regularly and/or frequently How often? _____
☐ I have gone to the emergency department because of my asthma Date: _____
☐ I have Chronic Obstructive Pulmonary Disease (emphysema or chronic bronchitis)
☐ I get short of breath walking 2 blocks or less ☐ I use home oxygen
☐ I have Sleep Apnea (stop breathing while you're sleeping) ☐ I use a CPAP machine ☐ I use a BIPAP machine
☐ Pneumonia in the past Last treated: _____ ☐ Tuberculosis Date treated: _____

CIRCULATION

☐ I have had Circulation problems for _____ years
(describe): _____
☐ I have a lot of bruising or bleeding that does NOT seem to have a cause
☐ I have a bleeding or clotting disorder ☐ I have hemophilia
☐ Blood clots in lungs (pulmonary embolism) ☐ Blood clots in legs (DVT)

☐ I take blood thinners:
☐ Aspirin
☐ Warfarin or Coumadin
☐ Plavix
☐ Other: _____

PHYSICAL ACTIVITY

☐ I get chest pain, pressure, or tightness when I climb 2 flights of stairs or less
☐ I have trouble breathing or become short of breath when I climb 2 flights of stairs or less

DIGESTIVE SYSTEM

☐ Heart burn, hiatus hernia, gastric reflux ☐ Stomach ulcers ☐ Bowel problems (Specify) _____

LIVER

☐ Hepatitis or Jaundice (yellowing in the skin) ☐ Cirrhosis

ENDOCRINE

☐ Thyroid Problems: _____
☐ Diabetes ☐ Taking insulin ☐ Taking pills ☐ Diet controlled

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KIDNEYS

☐ Bladder problems ☐ Prostate problems ☐ Kidney problems
☐ Kidney failure ☐ On Hemodialysis ☐ On Peritoneal dialysis
☐ Kidney transplant Date: _____

MUSCLES / JOINTS / NERVES

☐ History of weakness, paralysis, numbness, black outs (specify) _____
☐ Arthritis ☐ Osteoarthritis ☐ Rheumatoid arthritis
☐ Stroke Date: _____ ☐ Mini-stroke (TIA) Date: _____
☐ Seizures/Epilepsy: _____ ☐ Multiple Sclerosis ☐ Myasthenia Gravis ☐ Muscular Dystrophy

Have you ever had a:	**Where was the test done?**	**When?**
☐ Exercise stress test (treadmill)	_____	Date: _____
☐ Nuclear medicine heart scan (MIBI) test	_____	Date: _____
☐ Heart catheterization (angiogram)	_____	Date: _____
☐ Heart echo test (ultrasound of the heart)	_____	Date: _____
☐ Holter monitor (worn a heart monitor for 24 hours)	_____	Date: _____
☐ Lung function test (Pulmonary function test)	_____	Date: _____

Have you ever been seen by a:	**Name of Doctor?**	**When?**
☐ Heart Specialist (Cardiologist)	Dr. _____	Date: _____
☐ Lung Specialist (Respirologist)	Dr. _____	Date: _____
☐ Nerve Specialist (Neurologist)	Dr. _____	Date: _____
☐ Blood Specialist (Hematolgoist)	Dr. _____	Date: _____
☐ Other Specialist: _____	Dr. _____	Date: _____
☐ Other Specialist: _____	Dr. _____	Date: _____

List any surgeries or minor procedures you have had in the past using anesthesia

Operation/Minor procedure	Where was it done?	When?
_____	_____	Date: _____
_____	_____	Date: _____
_____	_____	Date: _____

Do you have any allergies? (for example: medicine, food, latex, tape, bandages)

I am allergic to:	My reaction:	**I am allergic to:**	My reaction:
_____	_____	_____	_____
_____	_____	_____	_____

List all of the medicines that you take (including herbal, vitamins, and non-prescription drugs)

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Tell us about any other serious illnesses or limitations that have not been identified already?

Questionnaire completed by:

Printed name: _____ Date: _____

If you are not the patient, what is your relationship to the patient? _____

For Pre-Assessment Clinic use only

☐ Reviewed by PAC RN Signature: _____ Date: _____

☐ Reviewed by Anesthesiologist Signature: _____ Date: _____