HOAG MEMORIAL HOSPITAL PRESBYTERIAN

PATIENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____

Stated Height: _____Stated Weight: _____

Primary Language: _____ Interpreter Needed? ☐ Yes ☐ No For which language? _____

Telephone #'s: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Contact Person: _____ Contact Phone Number: ( ) _____

INTERNIST/PRIMARY CARE PHYSICIAN AND VISIT INFORMATION

Internist/PCP: _____ Last Visit: _____ Next Visit: _____ Prior to Surgery? ☐ Yes ☐ No

Cardiologist: _____ Last Visit: _____ Next Visit: _____ Prior to Surgery? ☐ Yes ☐ No

Other Specialist: _____ Last Visit: _____ Next Visit: _____ Prior to Surgery? ☐ Yes ☐ No

ALLERGIES AND PREVIOUS SURGERIES

Allergies Title	Reaction

Previous Surgery Details	Surgery Year	Anesthesia Used

Please indicate if you have had any of the following CARDIAC/MEDICAL procedures listed below:

Angioplasty: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No Stent Placed? ☐ Yes ☐ No

Echocardiogram: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No

Stress Test: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No

Pacemaker: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No

Pacemaker Brand: _____ Pacemaker Model: _____

Other Procedure: _____

CARDIOVASCULAR

☐ Angina/Chest Pain
☐ Congestive Heart Failure
☐ Heart Valve Problems
☐ Pain or shortness of breath when walking 2 blocks or climbing 1 flight of stairs
☐ Arrhythmias, i.e., A-Fib
☐ Coronary Artery Disease
☐ High Cholesterol
☐ Cardiomyopathy
☐ Family History of Heart Disease
☐ History of DVT/PE
☐ Carotid Artery Disease
☐ Heart Attack
☐ Hypertension

Date of Heart Attack: _____ Date of Chest Pain: _____

Patient Name: _____

PULMONARY
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ CPAP
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Tuberculosis

HEMATOLOGIC
- ☐ Anemia
- ☐ Bleeding/Clotting Disorders
- ☐ Blood Transfusions
- ☐ Leukemia/Lymphoma

GASTROINTESTINAL
- ☐ Cirrhosis
- ☐ Digestive Problems
- ☐ Gastric Reflux
- ☐ Hepatitis A, B, or C

NEUROLOGIC
- ☐ Anxiety/Depression/Mood Disorders
- ☐ Dementia
- ☐ Fainting
- ☐ Headache
- ☐ Muscle Weakness
- ☐ Neuromuscular Disorders
- ☐ Numbness
- ☐ Seizures
- ☐ Stroke/Mini Stroke

GENITOURINARY
- ☐ Dialysis
- ☐ Kidney Stones
- ☐ Prostate Disease
- ☐ Urinary Tract Infections

ENDOCRINE
- ☐ Diabetes
- ☐ Hypo/Hyperthyroidism
- ☐ Hypoglycemia
- ☐ Recent Steroid Therapy

PAIN
- ☐ Artificial Joints, Location: _____
- ☐ Back/Neck Pain
- ☐ Chronic Pain Treatment
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis

GENERAL HEALTHCARE

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

Cancer:

Have you had or have cancer? ☐ Yes ☐ No
Have you had radiation therapy? ☐ Yes ☐ No
Have you had chemotherapy? ☐ Yes ☐ No
Where was/is the cancer located? _____

Have you had any of the following vaccines?

Ever taken the flu vaccine? ☐ Yes ☐ No
In what date: _____

Ever taken the pneumonia vaccine? ☐ Yes ☐ No
In what year: _____

For Female Patients:

Any possibility of pregnancy? ☐ Yes ☐ No
Date of last menstrual period? _____

Tell us about your social history:

Smoking History:

Do you smoke? ☐ Yes ☐ No
Have you ever smoked? ☐ Yes ☐ No
For how many years? _____
Any smoking in the past 12 months? ☐ Yes ☐ No

Alcohol History:

Do you drink alcohol? ☐ Yes ☐ No
How much alcohol do you consume and how often?
_____

Drug History:

Do you use recreational drugs? ☐ Yes ☐ No
What kind of recreational drugs do you use?
_____

Malignant Hyperthermia (MH) History:

Family history of MH? ☐ Yes ☐ No

SURGICAL INFORMATION

Do you exercise? ☐ Yes ☐ No If yes, Type: _____
Do you wear contact lenses? ☐ Yes ☐ No
Do you have caps, bridges, dentures or loose teeth? ☐ Yes ☐ No

SIGNATURES

[Patient/Parent/Conservator/Guardian] [Date] [Time] [If completed by other than patient, indicate relationship]

[Reviewed by Assessment Nurse] [Date] [Time] [Reviewed by Procedure Nurse] [Date] [Time]

[Reviewed by PACU Nurse] [Date] [Time] [Reviewed by Discharge Nurse] [Date] [Time]