

Health Questionnaire

(For OFFICE use only) DOS: _____ Arrival Time: _____

What surgery are you having? _____

General information: Height _____ Weight _____

Have you had a Flu vaccine? Yes (date _____) No

If you are age 65+, Have you had a Pneumonia vaccine? Yes (date _____) No

Other Vaccines Received and Date(s): _____

Do you have any medication allergies? Yes No Medication adverse reactions? Yes No

If **yes**, please list (include side effects): _____

CARDIAC

History of Cardiac Disorders? Yes No

If yes: Aneurysm Chest pain/angina Pacemaker Heart Murmur

Congestive Heart Failure High blood pressure Irregular Heartbeat Afib

High Cholesterol Heart attack - When? _____

Cardiac bypass surgery - # vessels _____ Angiogram/Stents: # of stents _____

Other: _____

RESPIRATORY

History of Respiratory Disorders? Yes No

History of Sleep Apnea? Yes No

If yes: Asthma Bronchitis Emphysema

COPD Pneumonia Clot in lungs (pulmonary embolus)

Other: _____

Do you use a CPAP at night when you sleep? Yes No

****If yes, please bring CPAP on the day of your surgery, if you will be staying overnight.**

Have you ever been diagnosed with COVID? Yes No

If yes, were you hospitalized due to COVID? Yes No

Comment: _____

SLEEP APNEA SCREEN/RISK

Do you Snore loudly? (louder than talking) Yes No

Do you often feel tired, fatigued, or sleepy in the daytime? Yes No

Has anyone observed you stop breathing while sleeping? Yes No

Do you have high blood pressure? Yes No

If **yes**, do you take 2 or more HTN meds? Yes No

Have you ever been diagnosed with type II diabetes? Yes No

BMI over 35? Yes No

Age over 50 years old? Yes No

Neck circumference large or shirt size > 17.5 inches? Yes No

Male Gender? Yes No

Health Questionnaire

NEUROLOGICAL (Brain/Spinal cord)

History of Neurological Disorders? Yes No

- If yes: Alzheimer's Dementia Parkinson's Paralysis (Quadra or Paraplegia)
 Headaches Seizures Multiple sclerosis
 Neuropathy Stroke TIA (Any residual deficits?) _____
 Numbness or tingling to hand Left Right
 Numbness or tingling to feet Left Right
 Other: _____

MUSCULOSKELETAL (Bones/Muscles/Ligament/Tendons/Joints)

History of Musculoskeletal Disorder? Yes No

- If yes: Arthritis Rheumatoid Arthritis Fibromyalgia
 Osteoporosis Chronic **back** pain Muscular Dystrophy
 Chronic **neck** pain Gout Other: _____

GASTROINTESTINAL (Digestive/Esophagus/Stomach/Colon/Rectum)

History of Gastrointestinal Disorders? Yes No

- If yes: Cirrhosis Crohn's disease Hiatal Hernia
 Irritable Bowel Syndrome Diverticulitis Diverticulosis
 Pancreatitis Peptic Ulcer(s) Ulcerative Colitis
 GERD Gastrointestinal bleeding Other: _____

URINARY (Kidney/Bladder)

History of Urinary Disorders? Yes No

- If yes: Prostate disease (BPH/Enlarged prostate) Cystitis
 Dialysis Urinary retention Kidney stones
 Chronic renal disease Incontinence UTI chronic
 Self-Catherization Other: _____

REPRODUCTIVE

Pregnant? Yes No LMP: _____ Breastfeeding? Yes No

History of Reproductive Disorders? Yes No

- If yes: Abnormal Pap Fibroids Irregular bleeding
 Ovarian Cyst STD Endometriosis
 Menstrual Disorder Menopause Low Testosterone
 Erectile Dysfunction Other: _____

EENT (Eyes/Ears/Nose/Throat)

History of EENT Disorders? Yes No

- If yes: Seasonal Allergies Hearing loss Glaucoma
 Cataract- Left Hearing device- Left Chronic Sinusitis
 Cataract- Right Hearing device- Right Other: _____

ENDOCRINE (Diabetes/Thyroid/Pancreas)

History of Endocrine Disorders? Yes No

History of Diabetes Mellitus? Yes No

- If yes: DM Type I DM Type II Hashimoto's

Health Questionnaire

- Hyperthyroidism **Hypothyroidism** Addison's
 Cushing Graves' Other: _____

Do you have an Implanted Insulin Pump? Yes No
 Make/Model of Pump: _____ Type/Name of Insulin Used: _____
 Basal Rate: _____ Bolus Settings: _____
 Target Blood Glucose Range: _____
 Do you wear a Continuous Glucose Monitoring System? Yes No _____

INTEGUMENTARY (Skin/Nails)

History of Integumentary Disorders? Yes No
 If yes: Cellulitis Eczema Shingles Rosacea
 Contact Dermatitis Psoriasis Other: _____

BLOOD

History of blood disorders? Yes No
 If yes: Anemia Hemophilia Sickle Cell
 Clotting problems Other: _____

CANCER

History of Cancer? Yes No
 If yes: Breast Liver Prostate Skin
 Lung Leukemia Kidney Ovarian
 Colon Cervical Uterine Other: _____

INFECTIOUS DISEASE

History of Infectious disease? Yes No
 If yes: AIDS HIV Hepatitis A/B/C HPV
 Herpes Tuberculosis MRSA/VRE (resistant org) Other: _____

MEDICAL PROCEDURES

History of Surgery? Yes No History of Invasive Procedure? Yes No
 If yes, please list: _____

Did you have any trouble with anesthesia? Yes No
 If yes, please list: _____

FAMILY HISTORY

	Mother	Father	Sibling	Other	Unknown
Cardiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke (CVA/TIA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

SMOKING/ALCOHOL STATUS

Health Questionnaire

- Current Everyday Current Someday Smoker Former Smoker Never
Amount of tobacco used? _____ Frequency of tobacco use? _____
How much alcohol do you drink? None 1-2 per week >2 per week Daily
Do you take any recreational drugs? Yes No

PSYCHOLOGICAL

- History of Psychological Disorders? Yes No
If yes: ADD Depression Panic Disorder
 ADHD Bipolar Disorder PTSD
 Anxiety Schizophrenia Other: _____

ABUSE/HUMAN TRAFFICKING SCREENING

- Do you have any concerns about your safety at home? Yes No
Have you been physically hurt or threatened by anyone? Yes No
Are you being forced to do anything you do not want to do? Yes No
Has your ID or documentation been taken from you? Yes No
Are there any safety issues you would like addressed while you are here in the hospital? Yes No
Were any of the above questions answered yes? Yes No

SUICIDE BEHAVIORS QUESTIONNAIRE

1. Over the past 2 weeks, have you felt down, depressed, or hopeless?
 - Yes
 - No
 - Patient unable to complete
 - Patient refused
2. Over the past 2 weeks, have you had thoughts of killing yourself?
 - Yes
 - No
 - Patient unable to complete
 - Patient
3. In your lifetime, have you ever attempted to kill yourself?
 - Yes
 - No
 - Patient unable to complete
 - Patient
4. If response to question #3 is YES:
 - Within the last 24 hours
 - Within the last month
 - Between 1 and 6 months ago
 - More than 6 months ago
 - Patient unable to complete
 - Patient refused

Health Questionnaire

PRIMARY CARE PHYSICIAN

Name and Phone: _____

LOCAL PREFERRED PHARMACY

Pharmacy Name: _____ Phone: _____

Address: _____ Zip Code: _____

PATIENT PORTAL ACCESS

Email: _____

CHG Education Provided: Yes No _____

(For OFFICE use only): B/P _____ R _____ HR _____ SPO2 _____ TEMP _____

Physician Notified for Abnormal Values- _____ Reported to: _____

Health Questionnaire

PATIENT MEDICATION LIST

Date: _____ Form Completed by: _____

Name of Medicine	DOSE	HOW OFTEN DO YOU TAKE IT	REASON FOR MEDICATION