WESLEY Medical Center
Intensive Caring

Health History Form

Please fill this sheet out and bring it with you to your Pre-Op Assessment Clinic visit and on the day of surgery. For more information to prepare for your surgery, visit www.wesleymc._____.

Patient Name_____

Date of Birth (MO/DAY/YYYY) _____ **Sex M/F** ☐☐

Date of Surgery_____

Reason for Surgery_____

Allergies/Intolerances

Medication/Food/Latex/Contrast Dyes	Describe Reaction

Surgeries

Surgery	Approximate Date

Please answer the questions below and check "Yes" or "No" in the boxes provided.

Do You Have?	Yes	No	Do You Have?	Yes	No
Glaucoma			Ostomy		
Cataracts			Change in Stools		
Nosebleeds			Hepatitis/Liver Disease		
Headaches			Hiatal Hernia		
Seizures			Rashes, Bruises, Sores		
Fainting/Dizziness			Diabetes		
Stroke			Do you check your blood sugar at home?		
Arthritis			Thyroid Disease		
Limited Mobility			Adrenal Disease		
Shortness of Breath			Cancer		
Frequent Colds/Sore Throat			Blood Disorders		
Chronic Cough			Bleeding		
Asthma			Anemia		
Bronchitis			Immune Deficiency		
Oxygen Use			HIV/AIDS		
Tuberculosis (TB)			Difficult/Painful Urination		
COPD (Emphysema)			Kidney Stones		
Sinus Infection			Frequent Urination		
Sleep Apnea			Prostate Problems		
High Blood Pressure			Kidney Disease		
Heart Attack			Urinary Tract Infections		
Chest Pain			Venereal Disease		

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Do You Have?	Yes	No	Do You Have?	Yes	No
Pacemaker			Dialysis		
Irregular Heart Rhythm			Last Menstrual Period If yes, date: _____		
Mitral Valve Prolapse			Completed Menopause		
Swelling of the Ankles			Currently Pregnant		
Heart Catheterization			Lactating		
Congestive Heart Failure (CHF)			Psychiatric Conditions		
Angioplasty (Stents)			Transplant Surgeries		
Blood Clots			Implanted Devices		
Heartburn			Latex Allergy		
Ulcers					

	Yes	No
Can we use either arm for blood pressures, IVs, or to draw blood?		
Have you had a tetanus shot in the last 10 years?		
Have you had a pneumonia shot in the last 5 years?		
Have you had a flu shot in the last year?		
History of Staph infections, MRSA?		
Have you ever had a blood transfusion?		
If yes, did you have any problems with it?		
Have you ever had a problem with anesthesia?		

Please answer "Yes" or "No" to the questions below. If needed, leave additional comments in the comments field.

	Yes	No
Do you smoke? If yes, how long? _____ How much? _____		
Do you drink alcohol? If yes, how long? _____ How much? _____		
Do you use caffeine? If yes, how much? _____		
Current or past use of recreational drugs?		
What is your preferred language?		
Do you live alone?		
Do you live in a nursing facility?		
Do you have a living will?		
Do you have a medical power of attorney?		
Have you lost the ability to walk in the last month?		
Can you get in and out of bed by yourself?		
Do you have difficulty swallowing?		
Have you lost 10 or more pounds recently without trying?		
Have you experienced loss of appetite in the last two weeks?		
Do you have any wounds that will not heal?		
Do you have a feeding tube or received TPN in the last month?		
Do you wear dentures? ☐ Uppers/Lowers ☐		
Do you wear a hearing aid?		
Do you wear glasses or contacts?		

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Medications

Please bring a **pharmacy print-out** of all prescriptions filled within the last 3 months, all **bottles of medications** taken every day or as needed, **OR** fill-out the medication portion of this form **including all of the following**:

- ✓ **Prescription medications** *(including insulin products)*
- ✓ **Over-the-Counter medications** *(ie. Ibuprofen, Aleve, Aspirin, etc)*
- ✓ **Herbal supplements** *(ie. Fish Oil, Chondroitin, etc)*
- ✓ **Vitamins/Multivitamins** *(ie. Vitamin E, Centrum Silver, etc)*
- ✓ **Dietary supplements** *(ie. Alli, Body Envy, etc)*
- ✓ **Medicated patches, creams, lotions, ointments**
- ✓ **Eye drops**
- ✓ **Nasal sprays**
- ✓ **Inhalers**
- ✓ **Regular injections at home or physician's office**
- ✓ **Please include any medications recently stopped for surgery**

Medication	Dose	Frequency	Reason
(Example: Tylenol	***1000mg***	***four times a day as needed***	***headache)***

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(Example: Tylenol	***1000mg***	***four times a day as needed***	***headache)***

Please list additional medications on the following page.

If you have questions, please call 316-962-7269 (Wichita area) or 1-800-732-0189 toll-free (outside the Wichita area).

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