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 |
|---|---|
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## Surgeries

| Surgery | Approximate Date |
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**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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**Patient Name**_____

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

| Do You Have? | Yes | No | Do You Have? | Yes | No |
|---|---|---|---|---|---|
| Pacemaker | | | Dialysis | | |
| Irregular Heart Rhythm | | | Last Menstrual Period<br>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? _____<br>How much? _____ | | |
| Do you drink alcohol? If yes, how long? _____<br>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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**Patient Name**________________________________________

## 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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| Medication | Dose | Frequency | Reason |
|---|---|---|---|
| ***(Example: Tylenol*** | ***1000mg*** | ***four times a day as needed*** | ***headache)*** |
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*Please list additional medications on the following page.*

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**Patient Name**_____

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