surgery center of GILBERT

Patient Health History

Name _____

All allergies (including tape, Betadine, latex, food, medications and environmental). Reactions? _____

_____

Previous Surgeries: _____

Any problems with anesthesia for you or your family? _____

Have you or anyone in your family been diagnoses with MRSA, VRE or C.Diff?
☐No ☐ Yes. Date & treatment _____

Please check all that apply to the patient only:

For Children Only

☐Reactive Airway Disease ☐Immunizations current Y / N ☐Chrosomal Disorder ☐ Loose Teeth
☐Full term / Premature birth ☐ Autism ☐ Downs Syndrome

Respiratory
☐Pneumonia/ Valley fever/ TB Chronic or frequent cough
☐Sleep Apnea/ CPAP machine
☐Shortness of breath/ Oxygen use _____liters
☐COPD - Bronchitis/ Asthma/ Emphysema

Cardiovascular
☐Pacemaker/ Defibrillator
☐Chest pain / Angina
☐Irregular heart rate
☐Swelling of hands, feet, or ankles
☐Rheumatic Fever
☐High blood pressure
☐Heart Murmur, Mitral valve prolapse (MVP)
☐Heart Attack / Congestive Heart Failure
☐Other: _____

Endo
☐Diabetes - diet/meds/insulin controlled
☐Thyroid disease

Skeletal
☐Back or neck problems, fractures
☐Arthritis / Rheumatism

Neuro
☐Fainting spells / seizures
☐Tremors / Restless Leg Syndrome
☐Weakness or paralysis of extremity / Stroke
☐Numbness or tingling of extremity
☐Anxiety/ Depression
☐Often or severe headache / Migraines
☐Memory loss/Alzheimer's disease/Dementia
☐Parkinson's Disease

Other
☐ Glaucoma
☐ Alcohol use, how often _____
☐ Smoking, how much/how long? _____
☐ Street drugs, what & how often? _____

GI / GU
☐ Liver or gallbladder problems
☐ Esophagus or colon problems
☐ Jaundice / Hepatitis
☐ Hiatal hernia / Acid reflux
☐ Kidney / Bladder / Prostrate problems
☐ Other _____

Skin
☐ Lesions / cancer / bruises
☐ Rashes / hives / eczema / psoriasis

Reproductive
☐ Pre / post menopausal
Date of last menstrual period _____
☐ Breast cancer / IIV or B/P restrictions
☐ Pregnant or breastfeeding?

Hemo
☐ Anemia / bleeding tendencies / blood transfusions
☐ Phlebitis / blood clots
☐ Blood diseases / HIV

Prosthesis / Joint Replacement
☐ Dentures / partial plates, upper or lower
☐ Hearing aids, right or left
☐ Glasses or contacts
☐ Metal implants, where? _____

Notes _____

Patient signature: History is correct to the best of my knowledge _____
☐No changes in medical history
History reviewed / RN signature: _____