SURGERY CENTER OF IDAHO

2855 E Magic View Dr
Meridian Idaho 83646

Adult Health History Questionnaire

Today's
Date: _____

Name: _____ DOB: _____ Surgeon: _____
Emergency Contact: _____ Relationship: _____
Phone Number: _____ Alternate Phone Number: _____
Person available to transport you home: _____ Phone Number: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

Do you have an Advance Directives? ❑ Yes ❑ No If yes, please bring a copy with you at the time of your surgery.

Do you wear or use:

❑ Glasses	❑ Dentures	❑ Crutches	❑ Wheelchair
❑ Contacts	❑ Partials	❑ Cane	
❑ Hearing Aids	❑ Dental Implants	❑ Walker	

Do you have reason to believe you may be allergic or have sensitivity to latex or rubber products?
❑ Yes ❑ No If Yes please describe: _____

Do you have allergies to food or medications? Please list, including reactions. ❑ **No known allergies**

Environmental / Food / Medications	**Reaction**

Please list current medications: Preferred Pharmacy: _____

Medications ❑ **No Medications**	**Dosage**	**Prescribing MD**

Please list all the times you have been admitted to the hospital for illness or surgery. ❑ **No Surgical History**

Year	**Surgery**	**Physician**

Have you ever been diagnosed for Methicillin-resistant Staphylococcus Aureus (MRSA)?
❑ Yes ❑ No If Yes please describe: _____

Have either you or a family member undergone general anesthesia AND had a reaction/difficulty with the anesthetic?
❑ Yes ❑ No If Yes please describe: _____

Have either you or a family member ever been informed that they experienced a Malignant Hyperthermia Episode?
❑ Yes ❑ No If Yes please describe: _____

Paperwork continued on back side

Have you had any of the following medical problems? If so, please place a (x) in the box next to it.

HEART
- □ Murmur
- □ Palpitations
- □ Irregular beats
- □ Chest pain / angina
- □ High blood pressure
- □ Heart failure
- □ Heart attack
- □ Heart surgery
- □ Ankle swelling
- □ Poor circulation

LUNG
- □ Recent cold
- □ Chronic cough
- □ Asthma
- □ Emphysema / COPD
- □ Difficulty breathing
- □ Shortness of breath
- □ Pneumonia
- □ Tuberculosis
- □ Sleep apnea
- □ Use CPAP / home oxygen / nebulizer

NERVE
- □ Dizziness
- □ Seizures
- □ Stroke or TIA
- □ Paralysis
- □ Multiple Sclerosis
- □ Fainting Spells

SKIN
- □ Rash
- □ Itching
- □ Night Sweats
- □ Cuts
- □ Abrasions
- □ Bruises
- □ Body Piercing

GASTRONINTESTINAL
- □ Recent nausea, vomiting
- □ Persistent diarrhea
- □ Black tarry stools
- □ Constipation
- □ Blood in stool
- □ Hiatal hernia
- □ Reflux / indigestion
- □ Ulcer

GENITOURINARY
- □ Difficulty urinating
- □ Burning with urination
- □ Blood in urine
- □ Frequency / urgency
- □ Incontinence
- □ Kidney stones
- □ Kidney disease
- □ Catheter

MUSCLE / JOINTS
- □ Weakness
- □ Numbness
- □ Muscle cramps
- □ Arthritis
- □ Neck Injury / surgery
- □ Back injury / surgery

OTHER
- □ Diabetes
- □ Hepatitis A B C
- □ Bleed easily
- □ Exposure to HIV / AIDS
- □ Anemia
- □ Liver diseases
- □ Thyroid
- □ Blood clot

Do you have any implanted devices such as a pacemaker, defibrillator, shunt, or a vagal stimulator?
❑ Yes ❑ No If Yes please describe: _____

_____

Cancer: ❑ Yes ❑ No If Yes please describe: _____

_____

Females: Are you pregnant? ❑ Yes ❑ No

Date of last menstrual period: _____

Date of sterilization procedure: _____

Do you have pain related to your surgical diagnosis? ❑ Yes ❑ No If Yes please describe: _____

_____

On a scale of 0 (none) to 10 (the worst), how would you rate your current pain? _____

What do you feel would be a tolerable pain level to achieve at time of discharge? _____

Do you have other chronic pains we should be aware of? ❑ Yes ❑ No If Yes please describe: _____

_____

What can we do to minimize your discomfort? _____

_____

Form completed by: ❑ Patient ❑ Other: _____ Signature: _____

_____ Date / Time: _____

Signature of Nurse Reviewing Data with Patient / Significant Other