NEWPORT BAY SURGERY CENTER

Health History Questionnaire

Name: ____________________________ **M/F** Age:_____ Wt:_____ Ht:______

Do you wear? *(Circle one)*
Contacts: Y N **Dentures:** Y N **Hearing Aids**: Y N Left/Right/Both

Allergies to Medications: ____
(Please list)
Allergies to Foods, Tape, Soap, LATEX, etc.____________________________________
(Please list)

Current Medications (Prescription/Over-the-Counter/Herbal)– *(please attach list if necessary)*

Medication	Dose/Mg	X per day	Medication	Dose/Mg	X per day
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Have you or a blood relative ever had a complication with anesthesia? ☐ Yes ☐ No
If yes, describe____

Previous Surgeries/dates ____

Medical History *(Check all that apply to you)*

Cardiac
☐ Angina/Chest Pain
☐ Congestive Heart Failure
☐ Irreg. Heart Beats
☐ Atrial Fibrillation
☐ Coronary Bypass #____
☐ High Blood Pressure
☐ Pacemaker

Lungs
☐ Asthma/Use Inhalers (Please bring your inhalers with you)
☐ Emphysema
☐ COPD/Use Oxygen at home?
☐ Bronchitis
☐ Allergies
☐ Sleep Apnea/Wear CPAP?
☐ Smoker, # Packs per Day

Thyroid
☐ Hyperthyroid
☐ Hypothyroid

Eyes
☐ Glaucoma ☐ Cataract surgery
☐ Retina surgery

Kidney
☐ Chronic Urinary Tract Inf.
☐ Dialysis, When_________
☐ Renal Failure

GI/Liver
☐ Hepatitis A,B,or C
☐ Cirrhosis
☐ Frequent Heartburn
☐ GERD/ Gastric Reflux

Diabetics
☐ Oral Meds
☐ Insulin Reg/NPH
☐ Diet Controlled

Central Nervous System
☐ Stroke/TIA's
☐ Seizures/Migraines
☐ Dementia/ Alzheimer's

Pregnancy Screen
☐ Possibility that you might be pregnant? If yes, please speak with your surgeon

Other
☐ Alcohol Use -How Often_________
☐ Drug Use -Specify__________
☐ Bleeding Disorders
☐ History of Mental Illness
☐ **Take/Have taken FLOMAX**
☐ History of Staph Infection

PATIENT STICKER

Patient/Guardian Signature:________________________________ **Date:**______________

There have been no changes to the above: ________________________ ____________
Patient Signature Date