Saint Mary's Regional Medical Center

HEALTH HISTORY QUESTIONNAIRE

Name:	Date of Birth:	Height:	Weight:

Past Medical History

☐ Alzheimer's/Dementia	☐ Arthritis	☐ Asthma
☐ Back or Spine Disorders	☐ Bleeding Disorders	☐ Heart Disorders
☐ Chicken Pox Exposure	☐ Clotting Disorders	☐ Depression/Psych Disorders
☐ Dialysis	☐ Digestive or GI Disorders	☐ Ears, Eyes, Nose & Throat Disorders
☐ Exposed to Communicable Disease	☐ Fracture or Trauma	☐ GYN Disorders
☐ Liver Disorders	☐ HIV or AIDS	☐ High Blood Pressure
☐ Immunocompromised	☐ Lung Disorders	☐ Kidney Disorders
☐ Rheumatic Fever	☐ Seizures	☐ Sleep Apnea
☐ STD	☐ Syncope or Vertigo	☐ Thyroid Disorders
☐ Tuberculosis	☐ Urinary Disorders	☐ No Significant History

History of Congestive Heart Failure (CHF)	☐ Yes	☐ No	Comment
History of Cancer (Current or Past)	☐ Yes	☐ No	Comment
Type of Cancer and Date/Age of Diagnosis			
History of Immunosuppression?	☐ Yes	☐ No	Comment
Have you received Chemo/Radiation Treatment within last 21 days?	☐ Yes	☐ No	Comment
History of Cardiomyopathy	☐ Yes	☐ No	Comment
History of COPD	☐ Yes	☐ No	Comment
History of Heparin induced Thrombocytopenia	☐ Yes	☐ No	Comment
History of Deep Vein Thrombosis (DVT)	☐ Yes	☐ No	Comment
History of Diabetes, Type 1	☐ Yes	☐ No	Comment
History of Diabetes, Type 2	☐ Yes	☐ No	Comment
History of Malignant Hyperthermia	☐ Yes	☐ No	Comment
History of Methicillin Resistant Staph Aureus (MRSA)	☐ Yes	☐ No	Comment
History of Organ Transplant	☐ Yes	☐ No	Comment
History of Stroke/TIA (Minor Stroke)	☐ Yes	☐ No	Comment
History of Extended Spectrum Beta Lactamase (ESBL)	☐ Yes	☐ No	Comment
History of Multi Drug Resistant Organism (MDRO)	☐ Yes	☐ No	Comment
History of Vancomycin Resistant Enterococcus (VRE)	☐ Yes	☐ No	Comment
Recent exposure to bed bugs, lice, etc.	☐ Yes	☐ No	Comment
History of sex confirmation surgery If yes, what organs were retained?	☐ Yes	☐ No	Comment
Are you currently experiencing abuse from another person?	☐ Yes	☐ No	Comment

Past Surgeries and Hospitalizations

☐ None	

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Additional Medical History	☐ Yes	☐ No	Comment _____		
History of Diarrhea Currently and/or Diarrhea in the Past Week	☐ Yes	☐ No	Comment		
History of C. Difficile (C Diff)	☐ Yes	☐ No	Comment		
Family or Close Contact History of C Difficile (C Diff)	☐ Yes	☐ No	Comment		
Wound Present on Admission	☐ Yes	☐ No			
Pressure Ulcer Present on Admission	☐ Yes	☐ No			
Currently Pregnant	☐ Yes	☐ No	☐ Not Applicable		
Breastfeeding	☐ Yes	☐ No	☐ Not Applicable		
Loose, Temporary or Capped Teeth	☐ Yes	☐ No			
Metal Implants	☐ Yes	☐ No			
Implant Location					
Immobility of Joints	☐ Yes	☐ No			
Joint Location					
Blood Transfusion History	☐ History of Transfusion Reaction ☐ Requires Pre-treatment	☐ No Transfusion History ☐ Unknown	☐ Prior Transfusion		
Medical Devices	☐ None ☐ Home Oxygen ☐ PICC ☐ Pain Management Pump ☐ Home Nebulizer	☐ Implanted Defibrillator ☐ Insulin Pump ☐ AV Shunt ☐ CPAP or BiPAP ☐ Other _____	☐ Perma Catheter ☐ Pacemaker ☐ Glucometer ☐ Stent(s)		
Currently in a Clinical Trial or Research Study?	☐ No	☐ Yes _____			
Currently Receiving Radiation Oncology Treatment?	☐ No	☐ Yes	☐ Yes, Other Location _____		
Patient Learns Best By	☐ Hearing	☐ Watching	☐ Doing	☐ Reading	

Family History	**Mother**	**Father**	**Brother**	**Sister**	**Daughter**	**Son**
Asthma	☐	☐	☐	☐	☐	☐
Chronic Obstructive Pulmonary Disease (COPD)	☐	☐	☐	☐	☐	☐
Congestive Heart Failure	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐
Type 1 Diabetes Mellitus	☐	☐	☐	☐	☐	☐
Type 2 Diabetes Mellitus	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐

Allergies

☐ None

Allergy	Reaction

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Medications, Supplements, Over the Counters		
☐ See My List **(Have Admitting Clerk make a copy and attach)** ☐ None		
Medication Name	Dosage	How Many Times Per Day

Cardiologist	
Have you ever seen a Cardiologist (Heart Specialist)?	☐ Yes ☐ No
When was your last appointment?	Name of Cardiologist or Group:

Pulmonologist	
Have you ever seen a Pulmonologist (Lung Specialist)?	☐ Yes ☐ No
When was your last appointment?	Name of Pulmonologist or Group:

Influenza
When was your last Influenza vaccine?

Alcohol Use			
Alcohol Use and Frequency	☐ None	☐ Occasionally	☐ 1-2 Daily
	☐ 3 or more Daily	☐ Weekly	☐ Binge Drinking
Last Use and Comments			

Tobacco Use, 13 Years of Age or Older	
Smoking status	☐ Current every day smoker ☐ Former Smoker ☐ Never Smoker
Have you smoked in the last 12 months?	☐ Yes ☐ No Comment
Approximately how many cigarettes per day?	
If you are a former smoker, when did you quit?	Date
Do you dip or chew Tobacco?	☐ Yes ☐ No Comment

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Drug Abuse			
DRUG ABUSE ☐ Yes ☐ No	☐ Amphetamines	☐ Bath Salts	☐ Club drugs
	☐ Cocaine	☐ Ecstasy	☐ Fentanyl
	☐ Heroine	☐ Inhalants	☐ K2/Spice (Synthetic Marijuana)
	☐ Ketamine	☐ LSD	☐ Marijuana
	☐ Methadone	☐ Methamphetamine	☐ PCP
	☐ Prescription Drugs	☐ Salvia	☐ Sedatives
	☐ Steroids (Anabolic)	☐ Other _____	
Frequency	☐ Daily	☐ Weekly	☐ Monthly
	☐ Occasionally	☐ Other _____	
Last Used			
Caffeine Use	☐ Yes ☐ No ☐ 1-2 daily ☐ 3 or more daily		

Have you travelled out of the U.S. in the last 28 days?	☐ Yes ☐ No Comment
Have you been hospitalized outside of the U.S. in the last 6 months?	☐ Yes ☐ No Comment

Vision		
☐ Normal	☐ Glasses	☐ Contact Lenses
☐ Blind Right Eye	☐ Blind Left Eye	☐ Blind Bilateral

Hearing		
☐ Normal	☐ Impaired Left	☐ Impaired Right
☐ Hearing Aid, Left	☐ Hearing Aid, Right	☐ Hearing Aids Bilateral

Personal Devices		
☐ None	☐ Cane	☐ Home Oxygen / Company Name
☐ Dentures Upper	☐ Wheelchair	_____
☐ Dentures Lower	☐ Prosthetic Limb	☐ Body Piercings _____
☐ Crutches	☐ Contact Lenses	_____
☐ Walker	☐ Insulin Pump	_____
Other Devices/Equipment/Personal Belongings. Please list if not listed above :_____		
_____		

Emergency Contacts	
Primary Contact Name:	Relationship:
Cell phone number:	Home Phone Number:
Work number:	
Designated Visitor:	

Living Situation			
☐ With Family	☐ Alone	☐ With Friends	☐ Foster Care
☐ Group Home	☐ Assisted Living	☐ Extended Care Facility	☐ Homeless

Receiving SMRMC Home Health and/or Hospice/ Palliative Care	SMRMC Home Health ☐ Yes ☐ No	SMRMC Hospice or Palliative Care ☐ Yes ☐ No
Receiving Another Agency Home Health Care or Hospice	☐ Yes ☐ No Comment	

Who will be driving you home after surgery?	
Driver's Phone Number	

Preferred Language	☐ English	☐ Spanish	☐ Other
Reading Language	☐ English	☐ Spanish	☐ Does Not Read