

HEALTH HISTORY

Patient Name (please print): _____ **Date:** _____

Birth date: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Primary Language, if other than English: _____

Occupation: _____ **Are you Right or Left Handed?** _____

Allergies (to Medications, Food, Latex, Environmental, Iodine)

Current Medications, Dosage, Frequency of Use (include prescription, over the counter medications, herbs, supplements)	

Previous Surgeries or Hospitalizations (include dates)	

Have you ever had a problem with anesthesia? (Circle those that apply to you:)
No Problem, Nausea and Vomiting, Malignant Hyperthermia, Slow to Wake Up, Wake up angry or wake up anxious
List any other problems you have had with anesthesia:
Have any of your Blood Relatives had a problem with anesthesia?

Reason you are being seen by a hand doctor: _____
Date of most recent injury _____
Prior hand/arm injuries and dates: _____

PRIMARY CARE DOCTOR _____ PHONE _____
HEART, DIABETES, LUNG OR OTHER SPECIALIST _____ PHONE _____

Patient Name (print) _____

DISEASE / MEDICAL CONDITION	YES	NO	DISEASE / MEDICAL CONDITION	YES	NO
High Blood Pressure			Asthma		
Heart Attack			Date of last attack:		
Irregular Heart Beat			Tuberculosis		
Is your Irregular Heart Beat on-going			Shortness of Breath		
Angina			Emphysema		
Is your Angina on-going			COPD		
Chest Heaviness			Sleep Apnea		
CABG (Please list year)			Home CPAP or Bi PAP (either)		
Stents (Please list year)			Pulmonary Hypertension		
Heart Valve Replacement			Home Oxygen		
Heart Catheterization			Diabetes; Diet Controlled		
Mitral Valve Prolapse			Diabetes; Oral Medication Controlled		
Congestive Heart Failure			Diabetes; Insulin Dependent		
High Cholesterol			Insulin Pump		
High Triglycerides			Rheumatoid arthritis (RA)		
Pacemaker, Type:			Osteoarthritis		
Manufacturer:			Arthritis		
Stroke (list year)			Osteoporosis		
If you have Seizures or Epilepsy, are you restricted from driving?			Gout		
Blood clot			Joint Replacement		
Blood Disease (e.g. Sickle Cell, vonWillebrand's) Describe:			Fibromyalgia		
Anemia			Cancer, Type: _____ Year: _____		
Blood Thinner - Reason:			HIV Positive		
Hepatitis A			AIDS		
Hepatitis B			Kidney Disease		
Hepatitis C			Renal Failure		
Reflux or GERD (either)			Back Problems		
Depression or Anxiety (either)			Neck Problems		
Multiple Sclerosis			History of MRSA		
Other Medical Conditions:			Thyroid		
			Currently Pregnant		

Social History:		
Do you smoke?	Yes or No	If yes, number of years? _____ Number of packs per day? _____
Have you quit smoking?	Yes or No	Year Quit _____
Do you drink alcohol?	Yes or No	If yes, Amount _____ Monthly, Weekly, Daily (circle)
History of Drug or Alcohol Abuse?	Yes or No	
Do you currently use recreational drugs?	Yes or No	

THE ABOVE INFORMATION IS CURRENT AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Patient / Guardian Signature

Date:

Patient / Guardian (please print)

Date:

Reviewing HSC RN N/A	HSC Anesthesiologist N/A
Date:	Date: