PATIENT SAFETY AUTHORITY
An independent agency of the Commonwealth of Pennsylvania

Health History

This sample form may be sent to the primary care physician or the referring physician for completion before the day of surgery. This form may be reviewed by anesthesia and nursing staff before the day of surgery, according to facility policy and procedure.

Patient Identification No: _____

Patient Name: _____ Age: _____ Date of Birth: _____ Today's Date: _____

Home Address: _____

Gender: _____ Height: _____ Weight: _____

Allergies: _____

Latex Sensitivity ❑ yes ❑ no

Advance Directive ❑ yes ❑ no

Language Spoken (if other than English): _____

Past Medical History (System)

(check and/or comment on all that apply)

Comment

Cardiovascular

- ❑ Angina _____
- ❑ Arrhythmia _____
- ❑ Coronary artery disease _____
- ❑ Myocardial infarction (date): _____ _____
- ❑ Hypertension _____
- ❑ Congestive heart failure _____
- ❑ Pacemaker _____
- ❑ AICD (automatic implantable cardioverter defibrillator) _____
- ❑ Other: _____ _____

Respiratory

- ❑ Asthma _____
- ❑ COPD (chronic obstructive pulmonary disease) _____
- ❑ Cough _____
- ❑ Shortness of breath _____
- ❑ Obstructive sleep apnea _____
- ❑ CPAP (continuous positive airway pressure) _____
- ❑ Other: _____ _____

Endocrine

- ❑ Non-diet-controlled diabetes _____
- ❑ Adrenal disorder _____
- ❑ Active thyroid disease _____
- ❑ Other: _____ _____

Hematologic

- ❑ Bleeding _____
- ❑ Bruising _____
- ❑ Clotting _____
- ❑ Anticoagulant use _____
- ❑ Drug and dose _____
- ❑ Other: _____ _____

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Continued . . .

Past Medical History (System)

Gastrointestinal — ***Comment***

- ❑ Hiatal hernia _____
- ❑ Gastroesophageal reflux _____
- ❑ Peptic ulcer disease _____
- ❑ Other:_____ _____

Neuromuscular/Musculoskeletal

- ❑ Seizure disorder _____
- ❑ Central nervous system disease _____
- ❑ TMJ (temporomandibular joint disorder) _____
- ❑ Cervical or thoracic spine pathology _____
- ❑ Other:_____ _____

Miscellaneous

- ❑ Oncologic process/chemo _____
- ❑ Hepatitis or jaundice _____
- ❑ Renal disease _____
- ❑ Morbid obesity (BMI [body mass index] greater than 30) _____
- ❑ Other:_____ _____

Infection/Isolation:

Site:_____ _____

Organism:_____ _____

Females — ***Comment***

- ❑ Possibility of pregnancy _____
- ❑ Date of last menstrual period _____

Previous Surgeries or Procedures (*describe as applicable*)

_____

_____

Anesthesia History	Yes	No	Don't know	Comments
Has the patient ever had anesthesia?	❑	❑	❑	_____
Has the patient ever had a problem with anesthesia?	❑	❑	❑	_____
Has a family member of the patient ever had a problem with anesthesia?	❑	❑	❑	_____
Has the patient or a family member had malignant hyperthermia?	❑	❑	❑	_____
Is there presence of any of the following:				
Loose or chipped teeth	❑	❑	❑	_____
Capped teeth	❑	❑	❑	_____
Trouble opening jaw, jaw clicking	❑	❑	❑	_____

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Continued . . .

	Yes	No	Don't know	Comments
Is there presence of any of the following:				
Dentures	❑	❑	❑	_____
Hearing aid(s)	❑	❑	❑	_____
Contact lenses	❑	❑	❑	_____

Prior Health Habits (indicate frequency in comments)	***Comments***
❑ Alcohol	_____
❑ Caffeine	_____
❑ Recreational drugs	_____
❑ Tobacco	_____

Current Medication History *(list all that apply, including herbal supplements and over-the-counter medications)*

Medication	Dose	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current pharmacy: _____

Physician completing form: _____
Signature of physician completing form: _____ Date: _____

For more information, go to http://www.patientsafetyauthority.org.
This form accompanies the following:
Patient screening and assessment in ambulatory surgical facilities.
Pa Patient Saf Advis
2009 Mar;6(1):3-9.

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