CYPRESS
Surgery Center

HEALTH HISTORY

HAVE YOU HAD OR DO YOU STILL HAVE ANY OF THE FOLLOWING?

	Y	N		Y	N		Y	N
Hay fever/Sinusitis			Bleeding or clotting problems			Braces, bridges, caps crowns dentures, retainers		
Recent cold/respiratory illness/ Bronchitis/Pneumonia/			**SEIZURES/EPILESPY**			Broken, chipped, missing or loose teeth		
ASTHMA			Stroke/Polio/Paralysis			Prosthetics/Orthopedic implants		
Emphysema			Tremor's/Parkinson's			Body piercing-where		
Tuberculosis			**HIV/AIDS**			Contacts/Glasses		
Sleep Apnea			Blood transfusion			Hearing aids		
Do you smoke? How much?			Nasal, facial, head, neck or back injuries			Do you drink alcohol Frequency_____		
Any other lung problems			Arthritis			Do you use street drugs Frequency_____		
HIGH BLOOD PRESSURE			**DIABETES**			HX of Post-op nausea & vomiting		
Chest Pain			Thyroid problem Kidney/Bladder problems			Any family members with difficulty or unusual reactions to anesthesia		
Fast or Irregular heart rate			**HEPATITIS/JAUNDICE LIVER PROBLEMS**			**Family history of MALIGNANT HYPERTHERMIA**		
Heart murmur/mitral valve prolapse			Hiatal hernia/acid reflux/ulcers GERD			Living will or Advanced Directives		
HEART ATTACK			Diagnosed with **MRSA** or have open or non-healing wounds (methicillin resistant staph aureus)			Any other medical problems or health issues we need to be aware of:		
Congestive heart failure			Eye muscle abnormalities					
Any other heart problem			Auto-immune diseases			FEMALES: LMP _____ (first day of last period)		
Any physical, mental or emotional limitations			Recent or current infection					
History of Falls/Uses Mobility Device (i.e. Cane, Walker, Wheelchair, etc...)								

ALLERGIES/REACTION	PREVIOUS SURGERIES
LATEX ALLERGY YES / NO	

NURSES NOTES/COMMENTS_____

☐ Reviewed with Pt. RN_____ DATE_____

PATIENT SIGNATURE_____