



- Mount Saint Joseph Hospital
- St. Paul's Hospital

## HEALTH HISTORY - Patient Questionnaire

Patient Name: \_\_\_\_\_  Male  Female Phone Number: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Alt. Phone Number: \_\_\_\_\_

### Do you have or have you ever had any of the following?

- I have had **problems** with local freezing (anesthetic) or general anesthetic (specify) \_\_\_\_\_
- A blood relative of mine has had **problems** with local freezing (anesthetic) or general anesthetic (specify) \_\_\_\_\_
- I have trouble or difficulty opening my mouth or moving my neck
- I have been a smoker for \_\_\_\_\_ years How many cigarettes a day? \_\_\_\_\_
- I drink alcohol How much do you drink in a week? \_\_\_\_\_
- I use street drugs Types: \_\_\_\_\_
- I am pregnant or could be pregnant Due Date: \_\_\_\_\_ or Date of last menstrual period: \_\_\_\_\_
- I have general body pain  I have ongoing pain Where? \_\_\_\_\_
- I am HIV positive

### Tell Us About Your Medical History

#### HEART

- Chest Pain or Angina How often: \_\_\_\_\_ Last date: \_\_\_\_\_
- Heart Attack(s) Date of most recent: \_\_\_\_\_
- High Blood Pressure for \_\_\_\_\_ years  Congestive Heart Failure for \_\_\_\_\_ years
- Irregular Heart Beat, Palpitations  Abnormal ECG/Heart Tracing
- Heart Murmur, Valve Problems, Leaky Valve  Pacemaker Date: \_\_\_\_\_
- Heart Surgery or Bypass Surgery Date: \_\_\_\_\_  Angioplasty Date: \_\_\_\_\_
- Automatic Implantable Cardioverter Defibrillator (AICD) Date: \_\_\_\_\_

#### BREATHING

- I have been admitted to the hospital within the last 6 months with shortness of breath
- I have Asthma  Only happens when I exercise or from environmental triggers
  - I use puffers regularly and/or frequently How often? \_\_\_\_\_
  - I have gone to the emergency department because of my asthma Date: \_\_\_\_\_
- I have Chronic Obstructive Pulmonary Disease (emphysema or chronic bronchitis)
- I get short of breath walking 2 blocks or less  I use home oxygen
- I have Sleep Apnea (stop breathing while you're sleeping)  I use a CPAP machine  I use a BIPAP machine
- Pneumonia in the past Last treated: \_\_\_\_\_  Tuberculosis Date treated: \_\_\_\_\_

#### CIRCULATION

- I have had Circulation problems for \_\_\_\_\_ years (describe): \_\_\_\_\_  I take blood thinners:
  - Aspirin
  - Warfarin or Coumadin
  - Plavix
  - Other: \_\_\_\_\_
- I have a lot of bruising or bleeding that does NOT seem to have a cause
- I have a bleeding or clotting disorder  I have hemophilia
- Blood clots in lungs (pulmonary embolism)  Blood clots in legs (DVT)

#### PHYSICAL ACTIVITY

- I get chest pain, pressure, or tightness when I climb 2 flights of stairs or less
- I have trouble breathing or become short of breath when I climb 2 flights of stairs or less

#### DIGESTIVE SYSTEM

- Heart burn, hiatus hernia, gastric reflux  Stomach ulcers  Bowel problems (Specify) \_\_\_\_\_

#### LIVER

- Hepatitis or Jaundice (yellowing in the skin)  Cirrhosis

#### ENDOCRINE

- Thyroid Problems: \_\_\_\_\_
- Diabetes  Taking insulin  Taking pills  Diet controlled





- Mount Saint Joseph Hospital
- St. Paul's Hospital

## HEALTH HISTORY - Patient Questionnaire

### KIDNEYS

- Bladder problems
  - Kidney failure
  - Kidney transplant
  - Prostate problems
  - On Hemodialysis
  - Kidney problems
  - On Peritoneal dialysis
- Date: \_\_\_\_\_

### MUSCLES / JOINTS / NERVES

- History of weakness, paralysis, numbness, black outs (specify) \_\_\_\_\_
  - Arthritis
  - Stroke
  - Seizures/Epilepsy: \_\_\_\_\_
  - Osteoarthritis
  - Rheumatoid arthritis
  - Mini-stroke (TIA)
  - Multiple Sclerosis
  - Myasthenia Gravis
  - Muscular Dystrophy
- Date: \_\_\_\_\_

Have you ever had a:

- |   | Where was the test done? | When?       |
|---|--------------------------|-------------|
| <input type="checkbox"/> Exercise stress test (treadmill)                   | _____                    | Date: _____ |
| <input type="checkbox"/> Nuclear medicine heart scan (MIBI) test            | _____                    | Date: _____ |
| <input type="checkbox"/> Heart catheterization (angiogram)                  | _____                    | Date: _____ |
| <input type="checkbox"/> Heart echo test (ultrasound of the heart)          | _____                    | Date: _____ |
| <input type="checkbox"/> Holter monitor (worn a heart monitor for 24 hours) | _____                    | Date: _____ |
| <input type="checkbox"/> Lung function test (Pulmonary function test)       | _____                    | Date: _____ |

Have you ever been seen by a:

- |  | Name of Doctor? | When?       |
|--|-----------------|-------------|
| <input type="checkbox"/> Heart Specialist (Cardiologist) | Dr. _____       | Date: _____ |
| <input type="checkbox"/> Lung Specialist (Respirologist) | Dr. _____       | Date: _____ |
| <input type="checkbox"/> Nerve Specialist (Neurologist)  | Dr. _____       | Date: _____ |
| <input type="checkbox"/> Blood Specialist (Hematologist) | Dr. _____       | Date: _____ |
| <input type="checkbox"/> Other Specialist: _____         | Dr. _____       | Date: _____ |
| <input type="checkbox"/> Other Specialist: _____         | Dr. _____       | Date: _____ |

List any surgeries or minor procedures you have had in the past using anesthesia

- | Operation/Minor procedure | Where was it done? | When?       |
|---------------------------|--------------------|-------------|
| _____                     | _____              | Date: _____ |
| _____                     | _____              | Date: _____ |
| _____                     | _____              | Date: _____ |

Do you have any allergies? (for example: medicine, food, latex, tape, bandages)

- | I am allergic to: | My reaction: | I am allergic to: | My reaction: |
|-------------------|--------------|-------------------|--------------|
| _____             | _____        | _____             | _____        |
| _____             | _____        | _____             | _____        |

List all of the medicines that you take (including herbal, vitamins, and non-prescription drugs)

- |       |       |       |       |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Tell us about any other serious illnesses or limitations that have not been identified already?

### Questionnaire completed by:

Printed name: \_\_\_\_\_ Date: \_\_\_\_\_

If you are not the patient, what is your relationship to the patient? \_\_\_\_\_

### For Pre-Assessment Clinic use only

- |   |                  |             |
|---|------------------|-------------|
| <input type="checkbox"/> Reviewed by PAC RN           | Signature: _____ | Date: _____ |
| <input type="checkbox"/> Reviewed by Anesthesiologist | Signature: _____ | Date: _____ |