Hoag Orthopedic Institute
Surgery Center

PLEASE BRING THIS COMPLETED FORM WITH YOU ON THE DAY OF SURGERY

PATIENT HISTORY QUESTIONNAIRE

Patient Name: ______________________________ Date of Birth: ______________ Age: ________

Stated Height: _______ Stated Weight: _______ Primary Language: ____________ Driver(s) Name: ____________

Driver(s) Telephone Numbers: 1st Number (   ) ________________ 2nd Number (   ) __________________

Procedure: ____ Date of Procedure: ______________

Physician performing procedure: __________________________ Primary Care Physician: ______________

Internist: ________________ Last seen: ________ Cardiologist: ______________ Last seen: ________

ALLERGIES and ALLERGY REACTIONS:

LIST PREVIOUS SURGERIES:	Year	Complications	Type of Anesthesia

LIST PREVIOUS CARDIAC/MEDICAL PROCEDURES: angioplasty/stent placement, echocardiogram, stress test, pacemaker or defibrillator model/brand #, and where done

Procedure	Year	

Please check appropriate box in each section below:

CARDIOVASCULAR	Yes	No		Yes	No
Hypertension	☐	☐	Angina/Chest Pain	☐*	☐
Heart Attack – Date: __________	☐	☐	Pain or shortness of breath when,		
Coronary Artery Disease	☐*	☐	walking 2 blocks or climbing 1 flight of stairs	☐*	☐
Cardiomyopathy	☐*	☐	High Cholesterol	☐	☐
Congestive Heart Failure	☐*	☐	Poor Circulation in lower extremities	☐	☐
Arrhythmias i.e. A-Fib	☐	☐	Family history of heart disease	☐	☐
Rheumatic Fever	☐	☐	(age of onset)		
Heart Valve problems/Aortic Stenosis	☐*	☐	Father Mother Siblings		
Heart murmur	☐	☐	_____ _____ ______		
Carotid Artery Disease	☐*	☐			
Pulmonary Hypertension	☐*	☐			

PULMONARY	Yes	No		Yes	No
Asthma	☐	☐	Blood clots in lungs or legs	☐	☐
COPD/Bronchitis/Emphysema (circle)	☐*	☐	Sleep Apnea	☐	☐
Pneumonia	☐	☐	Chronic Cough	☐	☐
Tuberculosis	☐	☐	Oxygen Use	☐*	☐

Label

GASTROINTESTINAL	Yes	No
Hiatal Hernia	☐	☐
Ulcers/GERD/Gastric Reflux (circle)	☐	☐
Gallstones	☐	☐
Liver Disease	☐	☐
Hepatitis A, B or C	☐	☐

GENITOURINARY	Yes	No
Urinary Tract Infections	☐	☐
Kidney Stones	☐	☐
Prostate Disease	☐	☐
Penile Prosthesis	☐	☐
Dialysis	☐*	☐

HEMATOLOGIC	Yes	No
Anemia	☐	☐
Bleeding Disorders	☐	☐
Blood Diseases i.e. Leukemia	☐	☐
Blood Transfusions	☐	☐
Easy Bruising	☐	☐

ENDOCRINE	Yes	No
Diabetes	☐	☐
Hypo/Hyperthyroidism	☐	☐
Hypoglycemia	☐	☐
Glaucoma	☐	☐

NEUROLOGIC	Yes	No
Stroke/TIA's	☐*	☐
Seizures	☐	☐
Multiple Sclerosis	☐*	☐
Myasthenia Gravis	☐*	☐
Paralysis	☐*	☐
Muscle Weakness	☐	☐
Headache	☐	☐
Fainting	☐	☐
Numbness	☐	☐

PAIN	Yes	No
Rheumatoid arthritis	☐	☐
Osteoarthritis	☐	☐
Chronic Pain Treatment	☐	☐
Back/Neck Pain	☐	☐
Artificial Joints	☐	☐
Location: ______________________		

GENERAL HEALTHCARE	Yes	No
Cancer	☐	☐
Location: ____________________		
Radiation Therapy	☐	☐
Chemotherapy	☐	☐
Immune Deficiency	☐	☐
TB Skin Test	☐	☐
☐ Positive ☐ Negative ☐ Unknown		

Social History:	Yes	No
Do you drink alcohol? Amount: ________	☐	☐
Do you smoke?	☐	☐
Did you ever smoke? Years: __________	☐	☐
Have you smoked in the past 12 months?	☐	☐
Do you use recreational drugs?	☐	☐
Type: _____________________________		
If female: possibility of pregnancy?	☐	☐
Last menstrual period: ______________		
History of Malignant Hyperthermia (MH)	☐*	☐
Family history of anesthesia problems or MH (circle)	☐*	☐

SURGICAL INFORMATION	Yes	No
Do you have any specific needs?	☐	☐
Hearing	☐	☐
Vision	☐	☐
Living alone	☐	☐
Transportation	☐	☐
Insurance	☐	☐
Do you exercise?	☐	☐
Type: _____________________________		

Do you need information on:	Yes	No
Current surgery	☐	☐
Medications	☐	☐
Activities	☐	☐
Home Care	☐	☐
Do you wear contact lenses?	☐	☐
Do you have caps, bridges, dentures or loose teeth?	☐	☐

_______________________________________ [Patient/Parent/Conservator/Guardian]

_______________________________________ [If completed by other than patient, indicate relationship]

______________ [Date]

THIS SECTION FOR FACILITY PERSONNEL USE ONLY

___________________ Reviewed by Nurse

________ Date

________ Time

_______________________ Reviewed by MD

________ Date

________ Time

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