HEALTH QUESTIONNAIRE

Instructions: Please complete this Health Questionnaire and bring it with you to the hospital.

Name: ______________________________ Height ________ Weight ________Date of Surgery: ____________

Allergies to Medications: ____

Allergies to Food/Environmental: ____

				Comments
1.	Have you or family member had a problem with anesthesia?	☐ No	☐ Yes	____________
2.	Do you smoke or ever smoked, when did you quit ? If so, how many packs per day?	☐ No	☐ Yes	____________
3.	Do you drink alcohol? If so how much?	☐ No	☐ Yes	____________
4.	Do you have chipped or loose teeth? Dentures?	☐ No	☐ Yes	____________
5.	Do you feel you bleed or bruise easily?	☐ No	☐ Yes	____________
6.	Are you on blood thinners?	☐ No	☐ Yes	____________
7.	Do you have a cold or are you recovering from one?	☐ No	☐ Yes	____________
8.	Do you have a history of blood clots?	☐ No	☐ Yes	____________
9.	Do you have pain? Where? ____________________	☐ No	☐ Yes	____________

Have you ever had:

10.	To stay over night in the hospital?	☐ No	☐ Yes	____________
11.	Epilepsy/Seizures?	☐ No	☐ Yes	____________
12.	Diabetes?	☐ No	☐ Yes	____________
13.	Lung Disease (e.g. emphysema, pneumonia, etc.)?	☐ No	☐ Yes	____________
14.	Asthma? Date of last attack ______________	☐ No	☐ Yes	____________
15.	Sleep Apnea?	☐ No	☐ Yes	____________
16.	Cancer?	☐ No	☐ Yes	____________
17.	Stroke?	☐ No	☐ Yes	____________
18.	Heart Problems (e.g. heart failure, Irregular beats, etc.)? Cardiologist ______________________________	☐ No	☐ Yes	____________
19.	Pacemaker? AICD? If yes, name of company? ______________	☐ No	☐ Yes	____________
20.	High blood pressure?	☐ No	☐ Yes	____________
21.	Liver problems (e.g. hepatitis, cirrhosis)?	☐ No	☐ Yes	____________
22.	Kidney or urinary problems (e.g. kidney failure or stones, enlarged prostate)?	☐ No	☐ Yes	____________
23.	Could you be pregnant? Date last menstrual period: ______________	☐ No	☐ Yes	____________
	Pregnancy test refused: ☐ Signature ____________________	☐ No	☐ Yes	____________
24.	Stomach problems (e.g. acid reflux, ulcers, etc.)	☐ No	☐ Yes	____________
25.	Bowel Problems (e.g. constipation, irritable bowel, etc.)	☐ No	☐ Yes	____________
26.	Emotional Problems (anxiety, depression, bipolar, etc.)	☐ No	☐ Yes	____________
27.	Dizzy spells/fainting?	☐ No	☐ Yes	____________

List all operations you have had: **Date or Age at Operation**

____

____

____

____

Who will take you home after your procedure?

Name: ______________________________ Relationship: ____________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

(See other side of page) →

Castle Medical Center Kailua, Hawaii

HEALTH QUESTIONNAIRE

PATIENT ID

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PATIENT QUESTIONNAIRE

FORM 1835 REV 3/14

Home Medications (Include prescription, non- prescription, herbal and vitamin supplements)			
Medication Name	**Dose**	**Route**	**Frequency**

Would you accept a blood transfusion if medically necessary?____

Nutritional Services Screen: Are you currently on a special diet? ____________________________________

Exercise screen: What kind of exercise do you do? ____

Have you had a flu vaccine in the past year? ☐ No ☐ Yes Date: ________________
Have you had a pneumococcal vaccine within the last 5 years? ☐ No ☐ Yes Date: __________________
Year of last tetanus vaccine: _______________ Year of TB skin test? ________________ ☐ Positive ☐ Negative
Do you have a history of infectious disease (MRSA, TB, Hepatitis) _____________________________________

Do you have an Advance Directive? ☐ No ☐ Yes
☐ Living Will ☐ Medical durable power of attorney ☐ Other ____________________________________
Does the hospital have a copy? ☐ No ☐ Yes

Do you have thoughts of harming yourself or others ☐ No ☐ Yes
Do you have a history of substance abuse (drugs/Alcohol) ☐ No ☐ Yes Date of last use? __________________
Do you live in a safe environment?____

Form Completed by: ____ **Date:** ______________

Reviewed by: _____________________________________ **RN Date:** ________________ **Time:** ______________

PATIENT ID