CENTRAL ARKANSAS SURGICAL CENTER

PATIENT HISTORY AND QUESTIONNAIRE

To assist us in making your surgical experience as safe as possible, we would like to have you answer a few health questions. Your co-operation is appreciated and all information will be kept confidential.

HT __________ WT __________ (Actual / Stated)   RECENT UNEXPLAINED WT LOSS OR GAIN YES / NO

REMINDER *** YOU MUST HAVE SOMEONE DRIVE YOU HOME *******

YES	NO	
		Have you had a recent: (please circle) Cold Fever Sore Throat Flu Sinus Problems Allergies Nasal Drainage Night Sweats
		Have you or your family ever had problems with anesthesia? High Fever Muscle Weakness Trouble Breathing Nausea
		Lung problems such as: (please circle) Asthma Wheezing Cough Shortness of Breath Bronchitis Chest Pains Sleep Apnea Last chest x-ray? ______________________ Use of CPAP or BIPaP machine? Y / N
		Alcohol use, Frequency__________ Qty____________
		Do you smoke? _______ Packs per day? ________ Have you ever smoked? ______Date quit________
		Do you currently use or have a history of illicit drug use? Explain______________________________
		Any heart problems such as: (please circle) High / Low Blood Pressure Heart Attack Skipped Beats Fainting Spells Pacemaker Heart Murmur Heart Failure /CHF Feet / Ankle Swelling If Yes: Explain ? _______________________________
		Have you ever had chest pains? Yes / No Explain: _______________________________
		When was your last EKG? (give date)___________________
		Are you anemic or have any bleeding disorders? (explain) ______________________
		Have you ever had a blood transfusion? __________ If yes when? ___________________
		Have you ever had problems with : Kidneys Thyroid Blood Clots Explain:____
		Have you ever had problems or difficulty with any of the following? Neurological problems Stroke/ TIA's Seizures/Convulsions Explain:_______________________
		Liver problems such as hepatitis?
		Stomach problems such as (circle) Hiatal Hernia Heartburn Ulcers Acid reflux/GERD
		Are you a Diabetic? ______ Did you check your blood sugar today? ______ Results_______ Time______
		History of : (please circle) arthritis, pain in your: Back Neck Arms Legs
		Have you ever had cancer? If Yes, What type_________________________ When?__________________
		List any other medical problems you are aware of?___________________________________
		Do you have a Living Will or Advanced Directive?
		HAVE YOU EVER HAD SURGERY BEFORE? ________ IF YES PLEASE LIST THE TYPE OF SURGERY AND YEAR (1) ____________________________ (2) _______________________________ (3)____________________________(4) _______________________________ (5) ____________________________ (6)________________________________

Patient Signature:_______________________________   **Initial Visit Label**

Date:____

2nd Visit   **3rd Visit**   **4th Visit**