# Patient
# Health Information

Name______________________________________________DOB____________Height__________Weight________

Family Doctor_____________________________________Cardiologist_____________________________________

**I currently take NO medications**: ❑ *(Check box if applies.)*
**Current Medications:**

- Include all prescription meds, over the counter meds, vitamins, herbals and inhalers.
- If you are unsure about what you are taking, please contact your doctor to find out.
- If you need more room, please attach a list of any additional meds to this form.

| Medication / Vitamins / Etc | Dose / Mg | Frequency & Time of Day AM / PM |
|---|---|---|
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Are you currently on oxygen? YES NO **If yes,** how many liters? _____________

**Do you have a history of any of the following? Circle YES for any corresponding symptom or condition.**

**MUSCULOSKELETAL:**

| | |
|---|---|
| Arthritis/Osteoporosis | Yes |
| Immobilizing Cast/Fracture | Yes |
| Fibromyalgia | Yes |
| Spinal Stenosis | Yes |

**ENDOCRINE:**

| | |
|---|---|
| Diabetes—Insulin Controlled | Yes |
| Diabetes—Oral Medications | Yes |
| Diabetes—Diet Controlled | Yes |
| Hypoglycemia | Yes |
| Thyroid Disease | Yes |
| Hypothyroid | Yes |

**VASCULAR:**

| | |
|---|---|
| Carotid Artery Disease | Yes |
| Vascular Disease | Yes |
| Aneurysm | Yes |
| Blood Clots -leg/lungs (yourself) | Yes |
| Blood Clots-leg/lungs (family) | Yes |
| Varicose Veins/Leg Swelling/Ulcers | Yes |

**GASTROINTESTINAL:**

| | |
|---|---|
| Reflux | Yes |
| Hernia—hiatal | Yes |
| Hernia—inguinal | Yes |
| Diverticulosis | Yes |
| Ulcers | Yes |
| IBS | Yes |
| Trouble Swallowing | Yes |

**WEIGHT:**

| | |
|---|---|
| Recent unexplained weight gain/loss of more than 10 lbs over the past 3 months | Yes |

**ENT:**

| | |
|---|---|
| Cataracts | Yes |
| Macular Degeneration/ Glaucoma | Yes |
| Sinusitis | Yes |

**CARDIAC:**

| | |
|---|---|
| Heart Attack | Yes |
| Congestive Failure | Yes |
| Mitral Valve Prolapse | Yes |
| Murmur | Yes |
| High Blood Pressure | Yes |
| High Cholesterol | Yes |

**PSYCHOLOGICAL:**

| | |
|---|---|
| Anxiety | Yes |
| Depression | Yes |
| Bipolar | Yes |
| Dementia | Yes |
| Alzheimer’s | Yes |

**BLOOD DISORDERS:**

| | |
|---|---|
| Anemia | Yes |
| Bleeding/Clotting Disorders | Yes |

**CANCER:**

| | |
|---|---|
| Chemo/Radiation | Yes |

**If yes,** which area was affected?

______________________________

**SKIN:**

| | |
|---|---|
| Eczema/Psoriasis | Yes |
| Pressure Ulcer | Yes |

Other:

______________________________

**RESPIRATORY:**

| | |
|---|---|
| Asthma | Yes |
| Bronchitis | Yes |
| Pneumonia | Yes |
| COPD | Yes |
| Sleep Apnea | Yes |

**If yes,** do you use

| | |
|---|---|
| C-PAP | Yes |
| BIPAP | Yes |

**RENAL:**

| | |
|---|---|
| UTI | Yes |
| Kidney Stones | Yes |
| Kidney Failure | Yes |
| Dialysis | Yes |
| Prostate Problems | Yes |

**NEUROLOGICAL:**

| | |
|---|---|
| Seizures | Yes |

**If yes,** when was your last seizure?

______________________________

**If yes,** what type of seizure did you have?__________________

| | |
|---|---|
| Mini-Stroke | Yes |
| Stroke | Yes |
| Multiple Sclerosis | Yes |

**INFECTION CONTROL:**

| | |
|---|---|
| Hepatitis | Yes |
| Sexually Transmitted Diseases | Yes |
| Herpes—genital | Yes |
| Shingles | Yes |

**If yes,** when was your last episode?__________________

| | |
|---|---|
| AIDS/HIV Exposure | Yes |

**If you answered yes to any of the above, please explain your answer below:**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

| | | |
|---|---|---|
| Have you ever had C. Difficile? | Yes | |
| Have you ever had MRSA? | Yes | Where Were You Tested?__________________ |
| Have you ever had VRE? | Yes | Where Were You Tested?__________________ |

## Allergy Information

**I have no known allergies:** ❑

- List ALL medications, foods, or environmental allergies.
- If you need more room, please attach a list of any additional allergies and reactions to this form.

| Allergy | Reaction | Allergy | Reaction |
|---|---|---|---|
| | | | |
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**Latex Allergy** Yes No **If yes,** what is the reaction?________________________

**Have you ever been tested for latex allergy?** Yes No

## Surgical History

**I have never had surgery :** ❑

- List ALL past surgeries with year.
- If you need more room, please attach a list of any additional surgeries and their dates to this form.

| Type of Surgery | Year | Type of Surgery | Year |
|---|---|---|---|
| | | | |
| | | | |
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### Anesthesia Risk:

Have you ever had general, spinal or other anesthesia? Yes No Any problems with it? Yes No

**If yes,** list reactions/problems:______________________________________________________________

Has any family member had problems with anesthesia? Yes No **If yes,** who (sibling/parent)?________

**If yes,** list reactions/problems:______________________________________________________________

### Implants/Prostheses:

Wires, pins, plates, screws: Yes No **If yes,** list site(s):________________________________________

Pacemaker: Yes No **If yes,** list manufacturer:__________________________________

Defibrillator (AICD): Yes No **If yes,** list manufacturer:__________________________________

Cardiac stent: Yes No

Vascular access port/catheter: Yes No

Intraocular lens implants: Yes No Right Left

Joint Replaced: Yes No **Hip:** Right Left **Knee:** Right Left **Shoulder:** Right Left

Dialysis catheter: Yes No

Breast implant(s): Yes No Right Left

Other: Yes No Describe:__________________________________________________

### Children Only (Under Age 18)

Are immunizations current? Yes No

### Adults Only (Age 18 or older)

Have you had a pneumonia vaccine? Yes No

**If yes,** when did you receive it? _________

## Women Only:

Are you pregnant? Yes No

If pregnant, number of weeks:________

Are you 4 weeks postpartum? Yes No

Date of last menstrual period: _________

Are you menopausal? Yes No

Are you post-menopausal? Yes No

## Social Risk Factors:

Do you smoke? Yes No

Year you started smoking: ____________________________________________________________

Year you quit smoking:______________________________________________________________

Packs per day you smoked: __________________________________________________________

Do you use smokeless tobacco? Yes No

Are you exposed to second hand smoke? Yes No

Is your lifestyle high risk for HIV? Yes No

Do you use drugs? Yes No

If yes what type of drugs: ____________________________________________________________

Do you use alcohol? Yes No

How many drinks per day? 0-1 1-3 3-5 5 +

Type of alcohol: ______________________________________________________________________

Do you feel you need an eye opener in the morning? Yes No

Have you ever felt guilty about drinking? Yes No

Do you use caffeine? Yes No

How may drinks daily? 0-1 1-3 3-5 5+

Do you exercise? Yes No

How many days a weeks? 0-1 1-3 3-5 5+

What type of activity: _________________________________________________________________

Do you use your seatbelt? Yes No

Do you feel safe at home? Yes No

Do you have a living will? Yes No

Do you have a Power of Attorney? Yes No

How often are you in the sun? Never Occasionally Frequent

## Impairments:

Are you hard of hearing? Yes No **If yes,** do you wear hearing aids? Right Left

Do you use a ❑ cane, ❑ walker, ❑ crutches, or ❑ wheelchair? *(Check box that applies.)*

Do you have any weakness/paralysis/special needs/disabilities? Yes No

Describe:___________________________________________________________________________________

Have you currently been confined to a bed for more than 72 hours? Yes No

Reason:____________________________________________________________________________________

## Dental/Optical Information:

Prescription Glasses Yes | Braces Yes | Reading Glasses Yes
Caps/Crowns Yes | Contacts Yes | Implants Yes
Dentures Yes | Partials Yes | Retainers Yes

## Miscellaneous:

Have you been hospitalized in the past two weeks? Yes No **If yes,** Hospital Name:____________________

Have you traveled outside of the United States in the last 30 days? Yes No

Would you accept a blood transfusion if needed? Yes No

Blood pressure/lab work restrictions: Yes No
Do not use my arm (due to medical restrictions) Right Left N/A

I have a Living Will or Advance Directive. Yes No
**If yes,** is it on file at St. Clair Hospital? Yes No
Designated Spokesperson:__________________________

Are you having back surgery? Yes No
**If yes,** please answer the following questions:

- Have you been to Europe since 1980? Yes No
- Have you ever been diagnosed with prion disease? Yes No
- Is there a family history of prion disease? Yes No
- Have you ever experienced a sudden rapid dementia? Yes No
- Have you ever had a dura mater transplant graft? Yes No
- Have you ever had a cadaver pituitary hormone injection? Yes No

## Family History:

| | NAME | LIVING: Y/N | AGE AT DEATH | MEDICAL HISTORY |
|---|---|---|---|---|
| **Mother** | | | | |
| **Father** | | | | |
| **Siblings:** | | | | |
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## Other Providers:

| | NAME | LOCATION | PHONE | FAX |
|---|---|---|---|---|
| **Oncologist** | | | | |
| **Pulmonologist** | | | | |
| **Pharmacy** | | | | |
| **Other** | | | | |
| **Other** | | | | |