

DISC SURGERY CENTER AT NEWPORT BEACH
Patient History Questionnaire



Patient Name: _____

Stated Height _____ Stated Weight _____

Primary Language: English / Other: _____

ALLERGIES / SENSITIVITIES / REACTIONS: PLEASE SEE MEDICATION RECONCILIATION FORM NKA

LIST PREVIOUS SURGERIES	Year	Complications	Type of Anesthesia

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

Please check appropriate box in each section below

CARDIOVASCULAR	Yes	No	NEUROLOGIC	Yes	No
Hypertension	[]	[]	Stroke / TIAs	[]	[]
Heart attack / angina / chest pain (circle)	[]	[]	Seizures	[]	[]
Coronary artery disease	[]	[]	Headache	[]	[]
Cardiomyopathy	[]	[]	Fainting	[]	[]
Congestive heart failure	[]	[]	Paralysis	[]	[]
Arrhythmias / irregular heartbeats	[]	[]	Steady gait	[]	[]
Rheumatic fever	[]	[]	Muscle weakness / numbness	[]	[]
Heart valve problems	[]	[]	Describe location: _____		
Heart murmur	[]	[]	_____		
Carotid artery disease	[]	[]	Do you use a cane / walker / wheelchair	[]	[]
Pain / SOB when walking 2 blocks or climb stairs	[]	[]	PAIN	Yes	No
Do you exercise?	[]	[]	Rheumatoid arthritis	[]	[]
High cholesterol	[]	[]	Osteoarthritis	[]	[]
Poor circulation in lower extremities	[]	[]	Chronic pain treatment	[]	[]
Family history of heart disease	[]	[]	Back / neck / other: _____ (circle)	[]	[]
PULMONARY	Yes	No	Describe pain on a scale of 0 – 10 : _____		
Asthma	[]	[]	Artificial joints	[]	[]
Last asthma attack: _____			Location: _____		
COPD / bronchitis / emphysema (circle)	[]	[]	GASTROINTESTINAL	Yes	No
Pneumonia / Tuberculosis	[]	[]	Hiatal hernia	[]	[]
Blood clots in arms or legs (circle)	[]	[]	Ulcer / GERD / gastric reflux	[]	[]
Sleep apnea	[]	[]	Gallstones	[]	[]
Do you use a CPAP machine?	[]	[]	Liver disease	[]	[]
Chronic oxygen use	[]	[]			

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GENERAL HEALTHCARE	Yes	No	HEMATOLOGY	Yes	No
History of MRSA (Methicillin-Resistant Staph-Aureus) Location: _____	[]	[]	Bleeding disorders / Easy bruising	[]	[]
Staph-Aureus Location: _____	[]	[]	Blood disease	[]	[]
Infectious disease: _____	[]	[]	Blood transfusions	[]	[]
Cancer: _____	[]	[]	Hepatitis A, B, C / HIV	[]	[]
Chemotherapy	[]	[]	GENITOURINARY	Yes	No
Do you wear contacts?	[]	[]	Urinary tract infections	[]	[]
Do you have dentures / partials?	[]	[]	Kidney stones	[]	[]
Do you have any loose or chipped teeth?	[]	[]	Dialysis	[]	[]
If female: possibility of pregnancy? Last menstrual period: _____	[]	[]	Prostate disease	[]	[]
ENDOCRINE	Yes	No	DO YOU NEED INFORMATION ON	Yes	No
Hypo / hyperthyroidism (circle)	[]	[]	Advance Directive	[]	[]
Hypoglycemia / hyperglycemia (circle)	[]	[]	Patient Rights and Responsibilities	[]	[]
Diabetic	[]	[]	HIPAA Notice of Privacy Practices	[]	[]
SOCIAL HISTORY	Yes	No	Payment and billing	[]	[]
Do you drink alcohol? Amount: _____	[]	[]	Current procedure	[]	[]
Do you smoke? How much: _____	[]	[]	Medications	[]	[]
Have you ever smoked? Years: _____	[]	[]	Home care / Transportation	[]	[]
Do you use recreational drugs? Type: _____	[]	[]			
History of malignant hyperthermia (MH)	[]	[]			
History of anesthesia problems	[]	[]			
Family history of anesthesia problems	[]	[]			

List any other pertinent information:

Patient / Guardian Signature: _____

Please bring this form with you on the day of admission. Bring a list of all medications / vitamins minerals that you have taken in the past 30 days.

REVIEWED BY	DATE	TIME
Preop RN		
Procedure RN		