Health Questionnaire NHRMC Pre-Testing
Please complete and bring with you to the Medical Mall

Name_____Date Of Birth:_____If Female last Menstrual Period:____
Home Phone:_____Cell Phone:_____
Height:____ Weight:____ Pain Goal AFTER Surgery (realistic goal is normally 3-5):_____
*Do you have a Living Will? Yes____No____ Would you like information about living wills? Yes____No____
Do you have a Health Care Power of Attorney? Yes ____ No____ Who? _____

* Any Spiritual / Cultural Requests: Yes___ No___ * If so please list:_____
* Suicide Risk: Have you recently had thoughts of hurting yourself or someone else: Yes____ No____
* Are you Physically / Verbally abused at home : Yes____ No____
* Do you live alone: Yes___ No___
* Do you have help at home after discharge from hospital: Yes___ No___
* Do you currently receive any home health services: Yes___ No___

*Please Check below if you currently have / require :

Dietary Restrictions:	**Eyes**	**Hearing**	**Dental**	**Assistive Devices**
[] None [] Diabetic [] AHA [] Renal [] Other_____	[] No problems [] Glasses/contacts [] Cataracts [] Glaucoma [] Blindness [] Detached Retina [] Macular degeneration [] Other_____	[] No problems [] Hard of Hearing [] Deafness [] Hearing Aids [] Menieres Disease [] Use Sign Language []Other_____	[] No problems [] False Teeth [] upper [] lower [] Partial Plate [] upper [ ] lower [] Caps/Crowns [] Missing [] TMJ [] Other_____	[] Cane [] Walker []Oxygen [] Wheelchair [] Other_____

Date Of Surgery:_____ Surgery to be performed:_____
* Have you been a patient at NHRMC before: Yes___ No___
* Have you made arrangements for transportation home after surgery: Yes___ No___
* Have you had a blood transfusion before: Yes___ No___ If so date:_____
* Would you accept a blood transfusion if needed: Yes___ No___
* Have you ever had an infection that would not go away (MRSA / VRE) Yes___ No___

Allergies:

Allergies	Reactions	Allergies	Reactions

*** Anesthesia History:**

* List any previous problems you have had with Anesthesia:

_____

* List any Life threatening problems with Anesthesia of any **BLOOD** relative:

_____

Medical History – Check which ones you have or have ever had:

Cancer

[] No history
[] Where:
[] Treatment:
[] Chemo [] Surgery
[] Radiation
[]
Other_____
Last treatment_____
[] Skin Cancer location on body_____

Neuro/Orthopedic

[] No problems
[] Arthritis
[] Seizures
[] Migraines
[] Neck Pain
[] Back Pain
[] Neuropathy
[] Stroke/TIA
[] Other:
_____

Heart

[] No problems
[] Heart Attack
DATE_____
[] Pacemaker / Defibrillator
[] Abnormal Rhythm
[] Murmur
[] Mitral Valve /MVP
[] Heart Failure / CHF
[] Chest Pain
[] High Blood Pressure
[] High cholesterol

Stomach

[] No problems
[] Reflux / GERD
[] Diverticulosis
[] Hemorrhoids
[] Hiatal Hernia
[] Severe Constipation
[] Severe Diarrhea
[] Crohn's / Ulcerative Colitis
[] Ulcers [] IBS
[] Polyps

Autoimmune

[] No problems
[] Chronic Fatigue
[] Fibromyalgia
[] Lupus
[] Multiple Sclerosis
[] Rheumatoid Arthritis

[] Other_____

Lungs

[] No problems
[] Asthma
[] COPD
[] Sleep Apnea
[] Short of Breath
[] Oxygen/CPAP
[] TB exposure
[]
Other_____

Liver

[] No problems
[] Hepatitis
[] Cirrhosis
[] Jaundice
[] Other_____

Skin

[] No problems
[] Psoriasis
[] Eczema
[] Rash
[] Rosacea
[] Open Wounds
[] Pre-Cancerous Lesions

Blood Disorders

[] No problems
[] Anemia
[] Sickle Cell
[] Abnormal Bleeding/Clotting
[] Blood Clot/Deep Vein Thrombosis
[] HIV

[] Other_____

Endocrine

[] No problems
[] Diabetes
[] Thyroid
[]
Other_____

Kidneys

[] No problems
[] Stones
[] Incontinence
[] Frequency
[] Hesitancy
[] Painful Urination
[] Enlarged Prostate
[] Insufficiency
[] Failure / Dialysis
[]
Other_____

Psychological

[] No problems
[] Anxiety
[] Depression
[] Panic Attacks
[] Memory Loss
[] Alzheimer's
[] Bipolar Disorder
[] Schizophrenia
[] ADHD / ADD
[] Other _____

List All of your PREVIOUS SURGERIES AND YEAR

1	6	11
2	7	12
3	8	13
4	9	14
5	10	15

* Do you drink alcohol? Yes___ No___ If yes, type: *Beer Wine Liquor*
How much per week____

* Do you use Recreational Drugs**:** Yes___ No___
What type:_____How often____

* Do you Smoke?: Yes___ No___ If so,how much_____ How many Years___
Quit date?_____

* Highest grade in school completed:_____

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