Northlake Surgical Center

PATIENT HISTORY

Name ______________________ Age ______ DOS __________ DR. ______________

Needs assistance reading form ☐ Yes ☐ No

GENERAL QUESTIONS

Allergies/Response (include food/latex) ______________________

Previous Surgery: ______________________

Recent Hospitalization in last 6 months: ______________________

Does the patient claim to be generally healthy? YES / NO HEIGHT ______ WEIGHT ______ LB.

Primary physician ______________________ ______ KG

1. Anesthesia in past	YES / NO
2. Problems w/Anesthesia/Malignant hyperthermia	YES / NO
3. Family Problems w/Anesthesia/Malignant hyperthermia	YES / NO
4. Smoker ____ # of packs/day ____ YRS	YES / NO
5. Alcohol Use ____ # of drinks/day ____ YRS	YES / NO
6. Active Infections/Diagnosed MRS/other antibiotic resistant infection	YES / NO
7. HIV/AIDS/Communicable Disease	YES / NO
8. Sleep Apnea/CPAP	YES / NO

CARDIAC

9. High Blood Pressure ☐ High Cholesterol ☐	YES / NO
10. Heart Attack Date ______	YES / NO
11. Angina/Chest Pain Freq./Last ep ______	YES / NO
12. Murmur/Valvular Problem	YES / NO
13. Abnormal EKG/Irregular Heartbeat	YES / NO
14. Heart Failure/Shortness of Breath/Pacemaker/AICD	YES / NO

PULM.

15. Emphysema	YES / NO
16. Bronchitis Last episode ______	YES / NO
17. Asthma Last Attack ______ ER Visit ______	YES / NO
18. TB exposure/Active/Latent	YES / NO
19. Pneumonia Date ______	YES / NO

NEURO/PSY-SOC

20. Seizure Frequency ______ Last ______	YES / NO
21. Stroke/TIA Date ______	YES / NO
22. Nerve or Muscle Problems	YES / NO
23. Back or Spinal Cord Problems	YES / NO
24. Psychiatric Diagnosis	YES / NO
25. Illegal Drug Use	YES / NO
26. Difficulty with Ambulation	YES / NO
27. Body Piercing	YES / NO
28. Hearing Problems/Aides	YES / NO
29. Vision Problems/Contact Lenses/Glasses	YES / NO
30. Language/Communication Needs	YES / NO

PED/HEME/ENDO

31. Cancer Type ______	YES / NO
32. Diabetes (Tx: Insulin-Oral-Diet)	YES / NO
33. Hiatal Hernia/Gerd/Acid Reflux	YES / NO
34. Liver or Kidney Disease (Hepatitis)	YES / NO
35. Thyroid Dysfunction Hypo ____ Hyper ____	YES / NO
36. Sickle Cell/Anemia/DVT/Clotting/Bleeding Problems	YES / NO
37. Pregnancy Possible/Last Menses ______	YES / NO
38. Immunizations Current (if child)	YES / NO
39. Premature Birth (if child)	YES / NO
40. Normal Growth/Development (peds)	YES / NO
41. Blood Transfusion Date ______	YES / NO
42. Recent Vaccinations (Smallpox)	YES / NO

MOBILITY

43. Mobility Needs (circle)

none cane crutches

wheelchair stretcher

Family History of (specify family member)

Diabetes YES / NO

____

Hypertension YES / NO

____

Cardiovascular Disease YES / NO

____

Primary Language:

☐ English ☐ Spanish ☐ Other ______

Needs Interpreter Yes / No

Pre-op Testing - Date/Where Done: ______

EKG: ______

Blood Work: ______

XRays: ______

Location of pain ______

Pain Scale (0-10) ______

COMMENTS (for Office Use):

____

Patient Signature Date

____

Reviewed by Date

PATIENT LABEL

NORTHLAKE SURGICAL CENTER
MEDICATION RECORD

Medication	Dose	Route	Time

OVER THE COUNTER MEDICATIONS (include vitamins and herbal supplements)

Medication	Dose	Route	Time

Patient or Responsible Adult ____________________ Date ____________________

Relationship to Patient ____________________ Nurse Signature ____________________