

Bellingham Surgery Center

Bellingham, Washington

HEALTH STATUS QUESTIONNAIRE

Date of Surgery:

Scheduled Time:

Patient Name:

Age:

Surgeon:

Surgical Procedure:

HEAD/EYES/NOSE/THROAT	NO	YES	RN'S	GENERAL HEALTH			
Loss?				Recent Fever/Chills			
Vision Loss?				Do you get shortness of breath,			
Glaucoma? Cataracts?				have chest pain or leg pain			
Sinus Problems?				if you climb a flight of stairs			
Seasonal Allergies?				or walk two blocks?			
TMJ Disease/Problems				Weight Loss/Loss of Appetite			
NEUROLOGICAL				Have you had any drug resistant			
Headaches? ___ Migraines? ___				organism? (MRSA-VRE)			
Seizures? ___ Last one? ___				Ever placed in isolation while			
Stroke? ___ When? ___				hospitalized?			
Numbness anywhere?				Other			
Muscle disease? _____				Child – immunizations current			
RESPIRATORY				HEMATOLOGIC			
Shortness of breath?				Bleeding problems?			
Recent cold or sore throat?				Anemia?			
Chronic cough?				Immune Disorders?			
Asthma? ___ episodes/wk ___				Recent blood transfusion?			
Emphysema?				SKIN/LYMPHATICS			
Use inhalers – times/wk ___				Enlarged glands?			
Home oxygen?				Rashes?			
Snoring? Sleep Apnea?				CANCER			
CARDIOVASCULAR				What type?			
High blood pressure?				When?			
Heart Attack?				Treatment?			
Chest pain (angina)?				MUSCULOSKELETAL			
Pacemaker/defibrillator?				Back or neck problems?			
Irregular heart rhythm?				Arthritis?			
Murmur?				Physical Limitations?			
Phlebitis/blood clots?				GENITOURINARY			
Congestive heart failure?				Kidney failure?			
Circulation problems?				Infections?			
Heart catheterization?				Prostate problems?			
Angioplasty?				Last menstrual period _____			
GASTROINTESTINAL				Could you be pregnant?			
Swallowing problems?				Birth control method?			
Heartburn/Reflux?				Prosthesis/Implants/Devices			
Hiatal Hernia?				Heart Valve _____			
Peptic Ulcer disease?				Joint _____			
Hepatitis? ___ A; ___ B; ___ C				Eyes _____			
Other liver disease?				Artificial limb _____			
ENDOCRINE				Hearing Aides _____			
Diabetes? How Long? _____				Dentures/partial _____			
Insulin ___ Oral Agent ___				Contact Lenses ___ Glasses ___			
Thyroid disease?				Walker/Wheelchair/Cane?			

— Continue on Other Side —

PREVIOUS SURGERIES

Blank lines for recording previous surgeries.

Problem with anesthesia or a family member with an anesthetic problem?

Yes No

ALLERGIES REACTIONS HABITS

To Medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		Treatment for drug or alcohol abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Recreational Drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide further information
		Alcohol? Drinks/day
Food? <input type="checkbox"/> Yes <input type="checkbox"/> No		Cigarettes? Per day When quit?
Latex? <input type="checkbox"/> Yes <input type="checkbox"/> No		Coffee? Cups/day?
Iodine? <input type="checkbox"/> Yes <input type="checkbox"/> No		ADVANCE DIRECTIVE
Tape? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No Located:
Soy Products? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Patient Rights and Responsibilities provided
Other?		

OTHER INFORMATION

Family Doctor	Specialist
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Patient Signature: _____ Date: _____

ADDITIONAL INFORMATION NEEDED TO COMPLETE CHART

Wt. _____ lb. _____ kg. HT. _____ BMI _____	1. Medical records sent for? Date: _____ Time: _____ 2. Test results requested? Date: _____ Time: _____ Lab, EKG, etc.
Escort's Full Name	
Phone No. <input type="checkbox"/> Call <input type="checkbox"/> Here	

Blank lines for additional information.

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PATIENT IDENTIFICATION