THE CENTER FOR SURGERY
Staffed for your specialty.SM

475 E. Diehl Road
Naperville, IL 60563
630.505.7733 phone
630.505.0656 fax

HEALTH HISTORY

Patient Name:

Height: Weight: BMI (for RN use):

Allergies:

Latex Allergies: ☐ Yes ☐ No

Please list any previous surgeries you've had:

Have you had any problems with Anesthesia? ☐ Yes ☐ No If yes, please explain:

Have any of your blood relatives ever had a serious problem with anesthesia that you know of? ☐ Yes ☐ No

If yes, please explain:

Do you smoke? ☐ Yes ☐ No How Much? _____

Do you drink alcohol? ☐ Yes ☐ No How Much? _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, list: _____

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HEALTH HISTORY

Please check Yes or No for each of the following conditions as they apply to you. *(This is not a family history but only things that pertain to your own history)* If yes, please explain briefly if appropriate:

Yes	No		
☐	☐	Heart Problems?	
☐	☐	Defibrillator?	
☐	☐	Stroke or Blood Clots?	
☐	☐	High Blood Pressure?	
☐	☐	Bleeding Tendency?	
☐	☐	Do you bruise easily?	
☐	☐	Hereditary Blood Disorders?	
☐	☐	Cancer? (Last chemotherapy or radiation treatment)	
☐	☐	Diabetes?	
☐	☐	Asthma, Emphysema, other lung problems?	
☐	☐	Kidney or Liver problems?	
☐	☐	Hepatitis?	
☐	☐	Seizures?	
☐	☐	Thyroid problems?	
☐	☐	Glaucoma?	
☐	☐	Stomach ulcers or hiatal hernia?	
☐	☐	Sleep Apnea? If yes, C-Pap? If yes, sleep study?	
☐	☐	HIV Positive?	
☐	☐	Do you have a living will or advance directive?	
☐	☐	Does someone have medical power of attorney for you?	

**If "yes", please bring necessary papers with you on the day of your procedure.*

For Pediatric patients only:

Is the child on an apnea monitor?
☐ Yes ☐ No Explain:

Was the child born prematurely?
☐ Yes ☐ No Explain:

Any congenital malformations?
☐ Yes ☐ No Explain:

The Center's Patient Rights / Patient Privacy / Advance Directives information is at:
Centerforsurgery.com

Please note any medications, vitamins or herbal supplements (Dosage Required) on Medication Reconciliation Record. *If you have a pre-printed list you may attach that to the form.*

For Office Use Only

Health History Reviewed and Pre-Op Instructions given: RN Signature: _____ Date _____

Info Obtained from: _____

Additional Information: _____