HEALTH HISTORY FORM

Preferred Name/ Nickname:	Approx Height	Approx Weight	Calculated BMI

ALLERGIES: ❑**NO** ❑**YES** (list on back of this form)
MEDICATIONS: ❑**NO** ❑**YES** (list on back of this form)

YES	NO	
		Previous **surgeries**? Please list them with approximate year (more space to write at bottom of page).
YES	NO	Have you or anyone in your family had a **reaction to anesthesia** (malignant hyperthermia, high fever, or other problem)?

If YES, please circle conditions below that apply to you.

YES	NO		YES	NO	
		Heart Attack / Angina / Chest Pain / Heart surgery or stents?			Diabetes: ❑Adult-onset Type 2 or ❑Insulin-dependent Type 1
		Pacemaker / AICD / Defibrillator Heart failure			Kidney or Bladder problems Thyroid
		High Blood Pressure / Fainting Low blood pressure			Bleeding / Bruising / Clotting Problem Anemia / Sickle Cell Disease
		Heart Murmur / Heart Valve / Mitral Valve Prolapse / Other heart disease			Heartburn / Reflux / Ulcers / Hiatal Hernia
		Irregular Heart Beat / Atrial Fibrillation			Hepatitis / Jaundice / Liver Problems
		Smoking? How much? Quit?			Frequent alcohol intake or dependence?
		Asthma (wheezing) / cough / pneumonia			Infectious Diseases / Tuberculosis / other
		COPD/ Emphysema/ Bronchitis			Dentures / Chipped or loose teeth / special dental work
		Sleep apnea CPAP? Yes No			Difficulty opening mouth / TMJ / Stiff neck
		Stroke / TIA / Numbness / Weakness Seizures (Epilepsy) Date of last one?			Drug use / Dependency: It is important for your safety to inform the anesthesiologist.
		Headaches / Neurologic-Nervous Disorder Anxiety / Depression			Arthritis (where?)

Who is your regular medical doctor/cardiologist?______________________________

When did you last see him/her?____________ Office phone #:______________

Comments or explain "YES" answers here:

The above information AND on the allergy medication form (other side) is accurate.

Patient/ Legal Representative Signature: ______________________________ Date: ________

ALLERGY & MEDICATION RECONCILIATION FORM

List allergies below (including **medications, latex, and foods)** and **what reaction** they caused.

Allergy	Reaction	Allergy	Reaction

List all medications you are currently taking. Include over-the-counter pills (like ibuprofen, Tylenol), transdermal patches, eye drops, inhalers, herbals/supplements, and oxygen.

Medication	Dose	Frequency	Reason for taking	Take or Hold On Day Of Surgery

****The Surgical Center of San Diego nurse will tell you whether to TAKE or NOT TAKE your medications on the day of surgery during the pre-operative phone call.**

⇩ NURSE to fill out from here down: ⇩

New Medication	Dose/Frequency	Route	Reason for Taking	Last Taken	Next Dose

RESUME YOUR REGULAR MEDICATIONS AS DIRECTED BY YOUR PHYSICIAN

❑ **Copy Given to Patient** PACU RN Signature ______________________________