PHYSICIANS
Surgical Center

1840 Quentin Road • Lebanon, Pennsylvania 17042
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PATIENT HEALTH HISTORY

Please complete the following information and bring it with you to the Physicians Surgical Center on the day of surgery.

Name: _____ **Age:** _____ **Sex:** ❑ **Male** ❑ **Female**

Height: _____ **Weight:** _____ **Person taking you home:** _____ **Phone #:** _____

Do you or did you have any diseases involving the following: (Check Yes or No and Circle the disease)

YES	NO	
		Heart: (heart attack/congestive failure/chest pain/irregular beat/valve problems/rheumatic fever/surgery/other)
		Lungs: (asthma/bronchitis/wheezing/shortness of breath/ emphysema/TB/chest cold in the last six weeks/other)
		Kidneys: (dialysis/failure/infection/stones/others)
		Circulation: (high BP/phlebitis/clots/poor circulation/other)
		Diabetes: (diet controlled/pills/insulin)
		Thyroid: (under active/over active/other)
		Liver: (yellow jaudice/hepatitis/cirrhosis/mono/other)
		Nervous System: (stroke/convulsions/paralysis/parkinsonism/ multiple sclerosis/myasthenia gravis/other)
		Psychiatric: (anxiety attacks/schizophrenia/depression/other)
		Digestive: (hiatal hernia/reflux/ulcers/indigestion/other)
		Teeth/Airway: (false/loose/caps/bridges/braces/retainers/ sleep apnea/trouble opening mouth)
		Contact Lenses: (soft/hard/extended wear) Removed

YES	NO	
		Muscles/Joints: (neck/jaw/arthritis/scoliosis/other)
		Other Significant Medical History: (cancer/glaucoma/ sinusitis/other)
		Tobacco: (chew/smoke ___ packs/day ___ years/quit ___)
		Alcohol: (social _____ /daily _____ /quit _____)
		Street Drugs: (marijuana/cocaine/IV drugs)
		Blood Transfusions/Blood Products
		Any chance you are pregnant?
		Have you taken Prednisone/Steroids within the last six months?
		Children Section Only: History of premature childbirth _____ _____ _____
		Anesthesia: Have you had any problems with anesthesia in the past? Have any of your blood relatives had trouble with anesthesia? Do you have anything you want to discuss regarding your anesthesia?

OTHER: _____

_____

MEDICATIONS: List all medications and dosages you presently take. Include any non-prescriptive, over-the-counter medications, herbal medications or vitamins, or any illegal drugs. ❑ None _____

_____

_____

_____

_____

_____

ALLERGIES: Medications / Latex / Other (please list below) _____

_____

_____

SURGICAL HISTORY: (Include all previous surgeries)

_____ Date _____

_____ Date _____

_____ Date _____