DOCTORS HOSPITAL OF MANTECA

HEALTH QUESTIONNAIRE

137

137 DHM 01/2020

This questionnaire is designed to assist the staff who will be taking care of you. It will help us to learn more about your health. Please fill it out as completely as possible and bring it to your appointment.

Name: _____ Birth date: _____ Gender: _____

Height: _____ Weight: _____ Allergies: _____

Contact phone number the night before your procedure/surgery: _____ Cell: _____

Type of procedure/surgery: _____ Scheduled for (date): _____

Have you had any of the following:

For hospital use only:

Lab work in the past 30 days (where)? ☐ No ☐ Yes: _____

EKG in the past 6 months (where)? ☐ No ☐ Yes: _____

Chest X-ray in the past 1 year (where)? ☐ No ☐ Yes: _____

Appointment with Primary Doctor/Provider (name/date): _____

Appointment with Specialist: Heart, Lung (name/date): _____

Date of Last Flu Vaccine: _____ **Date of last Pneumonia Vaccine:** _____

List of all surgeries	Year	Anesthesia	Problems with Anesthesia
_____	_____	☐ General / Loca ☐	No ☐ Yes: ☐ _____
_____	_____	☐ General / Loca ☐	No ☐ Yes: ☐ _____
_____	_____	☐ General / Loca ☐	No ☐ Yes: ☐ _____
_____	_____	☐ General / Loca ☐	No ☐ Yes: ☐ _____
_____	_____	☐ General / Loca ☐	No ☐ Yes: ☐ _____

Has any relative had a problem with anesthesia: No ☐ Yes ☐

If so, what: _____

Have you been hospitalized for an illness not requiring surgery: No ☐ Yes ☐

Illness: _____ Year: _____

_____ Year: _____

Habits (please circle):

Caffeine Use: ☐ NONE ☐ Minimal ☐ Moderate ☐ Heavy

Tobacco Use: ☐ NONE ☐ Cigarettes ☐ Cigars ☐ Vapor ☐ Chew ☐ Pipe

Amount _____ day/week/month/year Number of years _____ Date quit: _____

Alcohol Use: ☐ NONE ☐ Beer ☐ Wine ☐ Hard Liquor

Amount _____ day/week/month/year Number of years _____ Date quit: _____

Recreational Drug Use: ☐ NONE ☐ Marijuana ☐ Meth ☐ Other: _____

Amount _____ day/week/month/year Number of years _____ Date quit: _____

List street drugs: _____

*«PatientNumbe

«PatientName» «BirthDate»
ACCT# «PatientNumber» «AdmitDate» «AdmitTime»
«AdmittingDoctorName» MR:«MedicalRecordNumber» «Gender»
«Age»

Can you walk up two flights of stairs with minimal effort? No ☐ Yes ☐

Do you have, or have you ever had any of the following?
(check box then circle all that apply):

Respiratory
- Asthma / wheezing ☐
- Emphysema / COPD / chronic bronchitis ☐
- Sleep Apnea ☐
- Recent cold / illness ☐
- Shortness of breath rest / exertion / night ☐
- Current smoker ☐

Cardiovascular
- High blood pressure ☐
- High cholesterol ☐
- Angina / chest pain ☐
- Heart attack Year_____ ☐
- Coronary artery disease ☐
- Irregular heart beat ☐
- Heart failure / congestive failure ☐
- Murmur / rheumatic fever / valve issue ☐
- Pace maker / defibrillator ☐
- Cardiac Stent ☐

Renal / Endocrine
- Kidney: failure / stones / infection ☐
- Dialysis ☐
- Diabetes ☐
- Thyroid disorder: hypo / hyper ☐

Liver
- Liver disease / cirrhosis ☐
- Jaundice ☐
- Hepatitis ☐

GI
- Acid reflux ☐
- Ulcers / gastritis / vomiting blood ☐
- Frequent nausea / vomiting ☐

Neurologic
- Epilepsy / Seizures Date last_____ ☐
- Stroke / TIA Year_____ ☐
- Periods of dizziness / blackouts ☐
- Muscular dystrophy ☐
- Multiple sclerosis ☐
- Muscle disorder (weakness, paralysis) ☐

Hemotologic
- Anemia ☐
- Sickle cell anemia ☐
- Abnormal bleeding problem / bruise easily ☐
- Blood transfusion ☐

Other
- Neck pain / back pain ☐
- Arthritis – Degenerative / Rheumatoid ☐
- Artificial joint / prosthesis ☐
- Cancer Type_____ ☐
- Anxiety ☐
- Depression ☐
- Bipolar ☐
- Dementia ☐
- Religious restrictions ☐

Any other medical conditions not addressed above?

_____

_____

Is there any possibility you could be pregnant? ☐ NA ☐ Yes ☐ No

Dental Health: *(circle any that apply)*

Any teeth that are **loose, missing, chipped** or do you have **veneers**, a **bridge** a **partial**, or **dentures**?

If you are having anesthesia, do you have any questions for the anesthesiologist?

_____

Signature:_____ Date:_____

For hospital use only:

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PAGE 2 of 2

*«PatientNumbe

«PatientName» «BirthDate»
ACCT# «PatientNumber» «AdmitDate» «AdmitTime»
«AdmittingDoctorName» MR:«MedicalRecordNumber» «Gender»
«Age»