Providence Health Care

HEALTH HISTORY – PATIENT QUESTIONNAIRE

Place Patient Label Here

* 3 5 2 2 *

Medical Questionnaire

☐ Mount Saint Joseph Hospital ☐ St. Paul's Hospital

Last name:	First name:	☐ Male ☐ Female ☐ Other:_____
Address:		DOB: (dd/mmm/yyyy)
PHN:	Height ☐ cm ☐ inches	Weight: ☐ Kg ☐ Lb
Phone:		Alternate phone:

General Health Information (check all that apply)

- ☐ **Problems** with local freezing (anesthetic) or general anesthetic (specify) _____
- ☐ Blood relative had **problems** with local freezing (anesthetic) or general anesthetic (specify) _____
- ☐ Trouble or difficulty opening my mouth or moving my neck
- ☐ Tobacco Use - Smoker for _____ years How many cigarettes/cigars/pipes a day? ____
- ☐ Alcohol use: Average number of drinks per day ___ or ___per week?
- ☐ Substance use (non-prescription): Types
- ☐ Pregnant or could be pregnant Due Date: _____ or Date of last menstrual period: _____
- ☐ Chronic (ongoing) pain. Where? _____
- ☐ HIV /AIDS

Medical History (check all that apply)

HEART

- ☐ Chest Pain or Angina How often:_____ Last date:_____
- ☐ Chest Pain, pressure, or tightness when climbing 2 flights of stairs or less
- ☐ Previous Heart Attack(s) Date of most recent:
- ☐ Abnormal ECG/Heart Tracing
- ☐ High Blood Pressure for _____ years
- ☐ Congestive Heart Failure for _____ years
- ☐ Irregular Heartbeat, Palpitations
- ☐ Heart Murmur, Valve Problems, Leaky Valve
- ☐ Pacemaker / AICD (circle) Date Implanted: _____ Date Checked: _____
- ☐ Heart Surgery or Bypass Surgery Date:_____
- ☐ Angioplasty Date:_____

BREATHING

- ☐ Admission to the hospital within the last 6 months with shortness of breath
- ☐ Trouble breathing or become short of breath when climbing 2 flights of stairs or less
- ☐ Short of breath walking 2 block or less
- ☐ Asthma
  - ☐ Puffer use How often? _____
  - ☐ Visited the emergency department because of asthma Date: _____
- ☐ Chronic Obstructive Pulmonary Disease (emphysema or chronic bronchitis)
  - ☐ Use home oxygen
- ☐ Sleep Apnea (stop breathing while you're sleeping)
  - ☐ Use a CPAP machine
  - ☐ Use a BIPAP machine
- ☐ Pneumonia in the past Last treated: _____
- ☐ Tuberculosis Date treated: _____

CIRCULATION

- ☐ Bruising or bleeding that does NOT seem to have a cause
- ☐ Bleeding or clotting disorder
  - ☐ Hemophilia
  - ☐ Blood clots in lungs (pulmonary embolism)
  - ☐ Blood clots in legs (DVT)
- ☐ Treated with blood thinners:
  - ☐ Aspirin
  - ☐ Warfarin or Coumadin
  - ☐ Other: _____

PHYSICAL ACTIVITY / FUNCTION/ SOCIAL SUPPORT

- ☐ Walk_____ times per week
  - ☐ I use walker or cane
  - ☐ I have fallen in last 3 months
- ☐ Need help with eating, bathing ,dressing, toileting and walking
- ☐ Have help with cleaning, driving, shopping, cooking
- ☐ Community home support
- ☐ Memory problems
- ☐ Need help with taking my medication

DIGESTIVE SYSTEM

- ☐ Weight loss in the last 6 months without trying:
  - ☐ 2 to 13 lb ☐ 14 to 23 lb ☐ 24 to 33 lb ☐ more than 34 lb ☐ unsure
- ☐ Decreased appetite or chewing/swallowing difficulties
- ☐ Heart burn, hiatus hernia, gastric reflux

LIVER

- ☐ Hepatitis or Jaundice (yellowing in the skin)
- ☐ Cirrhosis

ENDOCRINE

- ☐ Thyroid Problems: (specify)_____
- ☐ Diabetes ☐ Taking insulin ☐ Taking pills ☐ Diet controlled

KIDNEYS

- ☐ Bladder problems ☐ Prostate problems ☐ Kidney problems ☐ Kidney failure
- ☐ Hemodialysis ☐ Peritoneal dialysis ☐ Kidney transplant: Date: _____

MUSCLES / JOINTS / NERVES

- ☐ History of weakness, paralysis, numbness, black outs (specify) _____
- ☐ Arthritis
  - ☐ Osteoarthritis
  - ☐ Rheumatoid arthritis
- ☐ Stroke Date: _____
- ☐ Mini-stroke (TIA) Date: _____
- ☐ Seizures/Epilepsy: _____
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Muscular Dystrophy

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Medical Questionnaire

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Have you ever had a:	**Where was the test done?**	**When?**
☐ Exercise stress test (treadmill)		Date:
☐ Nuclear medicine heart scan (MIBI) test		Date:
☐ Heart catheterization (angiogram)		Date:
☐ Heart echo test (ultrasound of the heart)		Date:
☐ Holter monitor (worn a heart monitor for 24 hours)		Date:
☐ Lung function test (Pulmonary function test)		Date:

Have you ever been seen by a:	**Name of Doctor?**	**When?**
☐ Heart Specialist (Cardiologist)	Dr.	Date:
☐ Lung Specialist (Respirologist)	Dr.	Date:
☐ Nerve Specialist (Neurologist)	Dr.	Date:
☐ Blood Specialist (Hematologist)	Dr.	Date:
☐ Other Specialist:	Dr.	Date:
☐ Other Specialist:	Dr.	Date:

List any surgeries or minor procedures you have had in the past using anesthesia

Operation/Minor procedure	Where was it done?	When?
		Date:
		Date:
		Date:
		Date:

Do you have any allergies? (for example: medicine, food, latex, tape, bandages)

I am allergic to:	My reaction:	**I am allergic to:**	My reaction:

List all of the medicines that you take: (including herbal, vitamins, and non-prescription drugs)

Tell us about any other serious illnesses or limitations that have not been mentioned already: (use reverse if necessary)

Questionnaire Completed by:

Printed name: _____ Date: (dd/mmm/yyyy)_____

If you are not the patient, what is your relation to the patient? _____