

# Day Surgery Health History Form



Please complete this form and return it, along with the Patient Registration Form, to Rapides Regional Medical Center, 211 Fourth Street, Alexandria, LA 71301, Attn: Pre-Admission Testing. Or you may fax it to (318) 769-7177. When you arrive for your scheduled surgery, please bring your insurance cards with you so that we can verify your coverage. Thank you for your cooperation.

Name \_\_\_\_\_

1. Please list any medication/food or latex allergies \_\_\_\_\_  
\_\_\_\_\_

2. What problems are you having? Why are you having surgery? \_\_\_\_\_

3. List any surgeries you have had in the past \_\_\_\_\_  
\_\_\_\_\_

4. Have you ever had problems with anesthesia? \_\_\_\_\_

5. Do you or anyone in your family have a history of any of the following (please check all that apply)?

- |   |   |   |   |   |  |   |                                    |   |                             |                                |
|---|---|---|---|---|--|---|------------------------------------|---|-----------------------------|--------------------------------|
| <input type="checkbox"/> You <input type="checkbox"/> Family Member | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> You <input type="checkbox"/> Family Member | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> You <input type="checkbox"/> Family Member | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> You <input type="checkbox"/> Family Member | <input type="checkbox"/> Cancer    |   |                             |                                |
| <input type="checkbox"/> Heart disease                              | <input type="checkbox"/> Allergies      | <input type="checkbox"/> Stroke                                     | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Mental disorder                            | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes                                   | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> TB | <input type="checkbox"/> Lupus |

6. Do you smoke? \_\_\_\_\_ How much daily? \_\_\_\_\_

7. Do you drink alcohol? \_\_\_\_\_ Do you use street drugs? \_\_\_\_\_

8. What medication(s) are you currently taking? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. How tall are you? \_\_\_\_\_ feet \_\_\_\_\_ inches

10. How much do you weigh? \_\_\_\_\_ pounds

11. Are you having any pain right now? \_\_\_\_\_

12. Do you have any hearing problems or wear hearing aid(s)? \_\_\_\_\_

13. Do you wear glasses or contacts or have vision problems? \_\_\_\_\_

14. Do you have any recent dizziness/fainting or neurological problems? \_\_\_\_\_

15. Do you have any breathing problems? \_\_\_\_\_

16. Do you have any heart problems? \_\_\_\_\_

17. Do you have any problems with poor circulation or blood clots? \_\_\_\_\_

18. Do you have any problems with your stomach or bowels? \_\_\_\_\_

19. How is your appetite? \_\_\_\_\_

20. Do you wear dentures or have any piercings in your mouth? \_\_\_\_\_

21. Do you have any problems with urination? \_\_\_\_\_

22. Do you have any problems with your reproductive organs? \_\_\_\_\_

23. Do you have sleep apnea? \_\_\_\_\_ If yes, do you use a CPAP? \_\_\_\_\_

24. Do you have any problems with walking or moving arms or legs? \_\_\_\_\_

25. Do you have any problems with skin (rash, open cuts, unhealed sores)? \_\_\_\_\_

26. Do you have a living will? \_\_\_\_\_ Are you an organ donor? \_\_\_\_\_

27. Are you (please circle one)    Married      Single      Divorced      Widow

28. Please list phone number(s) where you can be reached prior to your surgery:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

29. Please write any questions you have for the nurse:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_