Casper Surgical Center- Health History Assessment
1201 East Third Street, Casper, Wyoming 82601 (307) 577-2950

Name:_____ Age_____ Height_____ Weight_____ Patient Phone Number:_____
Sex: ❑ M ❑ F

Doctor:_____ Procedure: _____ Date of Surgery:_____

Cardiovascular

Are you now or have you ever been treated for:
Heart trouble: _____ ❑ Yes ❑ No
Heart murmur: _____ ❑ Yes ❑ No
Heart attack: _____ ❑ Yes ❑ No
Angina/chest pain: _____ ❑ Yes ❑ No
Pacemaker: _____ ❑ Yes ❑No
An irregular pulse: _____ ❑ Yes ❑ No
Congestive heart failure _____ ❑ Yes ❑ No
Blood Pressure: ❑ High or ❑ Low ❑ N/A _____
EKG in the last 3 months: ❑ Yes ❑ No Date:_____
Dr._____
Comments:_____
_____

Neurological

Are now, or have you ever been treated for:
Head Injury: _____ ❑ Yes ❑ No
Seizures/Convulsions: _____ ❑ Yes ❑ No
Blackout Spells: _____ ❑ Yes ❑ No
Stroke: _____ ❑ Yes ❑ No
Severe Headaches:_____ ❑ Yes ❑ No

In the past 2 weeks have you taken:
Tranquilizers:_____ ❑ Yes ❑ No
Comments:_____
_____
_____
_____

Respiratory

Do you have now, or have you ever had:
Breathing or lung problems: _____ ❑ Yes ❑ No
Asthma: _____ ❑ Yes ❑ No
Bronchitis: _____ ❑ Yes ❑ No
Emphysema: ❑ Yes ❑ No_____COPD: ___ ❑ Yes ❑ No
Tuberculosis: _____ ❑ Yes ❑ No
Have you ever been told you have sleep apnea ____ ❑ Yes ❑ No
Routine oxygen use: _____ ❑ Yes ❑ No

Do you Smoke or Chew Tobacco: _____ ❑ Yes ❑ No
packs/day:_____ How long: _____ ❑ Quit_____
Cans/week _____ How long:_____ ❑ Quit _____

❑ Instructed not to smoke or chew tobacco 12 hrs prior to surgery
Comments:_____
_____

Musculoskeletal

Do you have:
Muscle or joint pain: _____ ❑ Yes ❑ No
Back trouble: _____ ❑ Yes ❑ No
Arthritis: _____ ❑ Yes ❑ No
Limited joint movement:_____ ❑ Yes ❑ No

Comments:_____
_____
_____
_____

Are you able to complete the following tasks without being short of breath?
Walking around the house _____ ❑ Yes ❑ No
Climbing a flight of stairs _____ ❑ Yes ❑ No
Strenuous sports (football, basketball, skiing)__ ❑ Yes ❑ No

GI/GU

Do you have now, or ever had intestinal or stomach problems:
Ulcers:_____ ❑ Yes ❑ No
Bowel problems:_____ ❑ Yes ❑ No
Hiatal hernia: _____ ❑ Yes ❑ No
Other:_____
Liver problems:
Jaundice:_____ ❑ Yes ❑ No
Hepatitis:_____ ❑ Yes ❑ No
Other:_____
Kidney problems:_____ ❑ Yes ❑ No
Are you pregnant:_____ ❑ Yes ❑ No
Date of last menstrual period:_____
Comments:_____
_____

Endocrine

Do you have:
Diabetes: _____ ❑ Yes ❑ No
Diet controlled: _____ ❑ Yes ❑ No
Oral diabetic medications: _____ ❑ Yes ❑ No
Insulin:❑ Yes ❑ No Type:_____ Dosage:_____
Comments:_____
_____
_____

Hypoglycemia:_____ ❑ Yes ❑ No
Within the past year have you taken steroids:_____ ❑ Yes ❑ No
When:_____ Why:_____
Comments:_____
_____
_____

Immunizations/Exposures

Within the past 2 weeks have you been exposed to any infectious disease: _____ ❑ Yes ❑ No
If yes explain:_____
_____
Do you currently have an infectious disease:_____ ❑ Yes ❑ No
If yes explain:_____
_____
Are routine immunizations current:_____ ❑ Yes ❑ No
Comments:_____
_____
Do you have a bleeding problem? _____ ❑ Yes ❑ No
_____
Do you regularly take blood thinners or aspirin ___ ❑ Yes ❑ No
_____
Dose : _____ Frequency:_____
Instructed to stop blood thinners: _____ ❑ Yes ❑ No
When:_____

Allergies/Reactions

Are you allergic to anything:_____ ❑ Yes ❑ No
If yes explain & *type of reaction*:_____
_____
_____
_____
_____
_____
Do You have an allergy to latex? _____ ❑ Yes ❑ No
Describe:_____
_____
Have you ever had a blood transfusion reaction:_____ ❑ Yes ❑ No
If yes explain:_____
Have you or any blood relative ever had difficulty with a local or general anesthetic:_____ ❑ Yes ❑ No
_____
_____
_____

Previous Surgeries

Date	Type of Surgery	Date	Type of Surgery

Past Medical History

Have you ever had any cancer? ❑ Yes ❑ No	Type?	When?	How long?
Have you ever had Radiation therapy? ❑ Yes ❑ No	When?		How long?
Other treatments/therapy? ❑ Yes ❑ No	Do you have a Central Venous Catheter in place? ❑ Yes ❑ No Instructed to gain access ❑ Yes ❑ No		

Family Medical History

Family History of Cancer? ❑ Yes ❑ No	Whom?	Details:
Family History of Heart Disease? ❑ Yes ❑ No	Whom?	Details:
Family History of Stroke? ❑ Yes ❑ No	Whom?	Details:

Other:

Medications/Prescriptions/Over the Counter/Herbal Supplements

Name	Dose	Frequency		Name	Dose	Frequency
				Preop Medication instructions given: ❑ Yes ❑ No ❑ N/A		

ADL's/Self Care

Normal hearing:_____❑ Yes ❑ No Hearing aid: _____ ❑ Yes ❑ No Deaf:_____ ❑ Yes ❑ No Decreased hearing:___ ❑ Yes ❑ No Normal vision:_____ ❑ Yes ❑ No Glasses:_____ ❑ Yes ❑ No Contact lenses: ____ ❑ Yes ❑ No Glaucoma: _____ ❑ Yes ❑ No ↓ Vision: _____ ❑ Yes ❑ No **Comments:**_____	Normal mobility:____ ❑ Yes ❑ No Crutches: _____ ❑ Yes ❑ No Walker: _____ ❑ Yes ❑ No Wheelchair: ____ ❑ Yes ❑ No Non ambulatory: ___ ❑ Yes ❑ No Normal Dentition: ___ ❑ Yes ❑ No Dentures: _____ ❑ Yes ❑ No Partial plate: _____ ❑ Yes ❑ No Bridges: _____ ❑ Yes ❑ No Loose teeth: ____ ❑ Yes ❑ No Capped teeth:___ ❑ Yes ❑ No	Requires assistance with: Dressing: _____ ❑ Yes ❑ No Sitting: _____ ❑ Yes ❑ No Transferring: _____ ❑ Yes ❑ No Ambulates w/o assist ❑ Yes ❑ No _____ Orientation: ❑ Person ❑ Place ❑ Time Normal Speech:_____ ❑ Yes ❑ No Speech Impediment:____ ❑ Yes ❑ No **Comments:**_____	Any learning or developmental disabilities: _____ ❑ Yes ❑ No If yes explain:_____ _____ _____ _____ **Do you use alcohol**: ❑ Yes ❑ No Type:_____ Amount:_____

Psychological/Social

Religious or Cultural beliefs which may affect treatment or care:	Do you have? Advanced Directives ❑ Yes ❑ No Donor Card? ❑ Yes ❑ No
Do you have any questions or concerns about this procedure?	Legal Guardian: Guardianship Documents on the chart ❑ Yes ❑ No Explain:
Lives with:	Primary Language:

Person accompanying patient to the Center:
Name: Relationship: Phone # h): w):

Person to contact for patient discharge:
Name: Relationship: Phone # h): w):

Reviewed: Smoking Policy ❑ Yes ❑ No Visitor Policy ❑ Yes ❑ No Instructed to remove all body piercing ❑ Yes ❑ No ❑ N/A

Signature of Nurse taking health history: **Date:**

Surgeon Signature: **Date:**

Anesthesiologist Notes:

Anesthesiologist Signature: **Date:**

Reviewing Nurse's Signature: **Date:**