PATIENT HEALTH SURVEY

Name | Phone #

Date:

Do you have any of the following: Language, Visual, Auditory, or Cultural Disabilities that would have a bearing on your care? No or Yes, If yes, please describe: _____

_____

	Yes	No	Any Comments
Do you have a Living Will?			
Are you allergic to any medication?			
12yrs of age & older - do use cigarettes, alcohol & substance abuse			

Do you take any medication daily? (please write those taken) Please list below

Medication	Diagnosis	Dose	Frequency

	Yes	No	Any Comments
Do you have or wear dentures, bridges?			
Are any teeth loose or chipped?			
Do you smoke? If so, how many packs per day?			
Do you drink alcohol, or beer daily?			
Have you or your relative had previous problems with anesthesia? If yes, describe.			
Have you had an operation before?, please describe.			
Have you ever had a blood transfusion?			
Is it possible you may be pregnant? Date of last menstral period:			

Have you ever had (or still have) any of these problems:

- ☐ Bronchitis
- ☐ Emphysema
- ☐ Phlegm
- ☐ Asthma, Wheezing
- ☐ Short of Breath
- ☐ Heart Attack
- ☐ Chest Pain, Angina
- ☐ Hypertension
- ☐ Pacemaker
- ☐ Kidney Problem
- ☐ Liver Problem, Hepatitis, Jaundice
- ☐ Bruise or bleed easily
- ☐ Anemia
- ☐ Sickle Cell Anemia
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Blackout
- ☐ Stroke, Dizziness
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Nervous Disorder
- ☐ Hiatal Hernia, Heartburn
- ☐ Any other medical problem