

Grossmont Surgery Center
Health History Questionnaire

Name: _____

Date of Surgery: _____

When (at what time) did you last have anything to eat? _____ or drink? _____

Previous Surgeries: Year: Type of Anesthesia: Complications: Nausea Post-Op?

Medication Allergies: _____

Environmental/Food Allergies: _____ **Tape:** _____ **Latex:** _____

Latex Screening: (If Yes to any one below, refer to Latex Screening form)

YES NO

- ____ ____ Reported Latex Allergy? What Happens to you? _____
____ ____ Spina Bifida
____ ____ Reaction after medical dental treatment?
____ ____ Allergies to bananas, chestnuts, avocados, kiwis
____ ____ Healthcare worker or other occupational exposure

MEDICAL HISTORY

YES NO

- Heart Attack/Heart Disease
 Chest Pain/Angina
 Irregular Heart Beat
 Mitral Valve Prolapse
 High Blood Pressure
 Pacemaker/Defibrillator
 Stroke
 Lung Disease/TB
 Asthma/Emphysema
 Wheezing
 Any other illness or chronic pain: _____

YES NO

- Diabetes
 Kidney Disease
 Sleep Apnea (CPAP)
 HIV/Autoimmune Disorder
 Hepatitis/Jaundice
 Ulcers/Hiatal Hernia
 Bleeding Tendency
 Bruise Easily
 Epilepsy/Seizures
 Motion Sickness

YES NO

- Migraine Headaches
 Arthritis/Back Pain
 Herpes/Shingles
 Glaucoma
 Thyroid Disease
 Cancer _____
 Depression/Mental Illness

Pre-Operative Anesthesia Evaluation

BP: _____ T: _____ P: _____ RR: _____ O2: _____ Pain: _____

Psychosocial: Appropriate Calm Cheerful Angry Nervous Crying

Labs/EKG Reviewed Blood Sugar: _____ Other: _____

Physical Exam: Heart: _____ Lungs: _____ Airway: _____

Anesthesiologist Evaluation:

ASA Physical Status: 1 2 3 4 Plain: MAC Local Block Other _____

Anesthesiologist Signature: _____ Date/Time: _____

