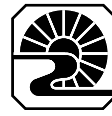
Day Surgery
Health History Form


Rapides Regional Medical Center

If you are completing this form at an outside facility, please complete and fax to our pre-admission testing unit at (318) 769-7052. Thank you for your cooperation.

Name ____

1. Have you traveled outside of the Unites States in the past 3 weeks? If so, where? ____________________
2. Please list any medication/food or latex allergies ______________________________________

   ____
3. What problems are you having? Why are you having surgery? ______________________________
4. List any surgeries you have had in the past ____

   ____
5. Have you ever had problems with anesthesia? ______________________________________
6. Do you or anyone in your family have a history of any of the following (please check all that apply)?

You	Family Member		You	Family Member		You	Family Member		You	Family Member	
☐	☐	Kidney disease	☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Cancer (Type) ________
☐	☐	Heart disease	☐	☐	Blood disorder	☐	☐	Hepatitis	☐	☐	TB
☐	☐	CHF	☐	☐	Seizure disorder	☐	☐	Thyroid problems	☐	☐	Lupus
☐	☐	Emphysema	☐	☐	Mental disorder	☐	☐	Blood clots	☐	☐	Blood disorder (HIV, Sickle Cell)
☐	☐	Stroke	☐	☐	High blood pressure	☐	☐	Staph Infections			

7. Do you smoke? __________ How much daily? ____________________
8. Do you drink alcohol? ____
9. Do you use illicit street drugs? ________ Which type? ____________________ How often? ________________
10. How tall are you? _______feet _______inches
11. How much do you weigh? _______pounds
12. Are you having any pain right now? If yes, where? ______________________________________

13. Do you have any hearing problems or wear hearing aid(s)? ___________________________

14. Do you wear glasses or contacts or have vision problems? ___________________________

15. Do you have any recent dizziness/fainting or neurological problems? ___________________________

16. Do you have any breathing problems? ___________________________

17. Do you have any heart problems? ___________________________

18. Do you have any problems with poor circulation or blood clots? ___________________________

19. Do you have any problems with your stomach or bowels? ___________________________

20. How is your appetite? ___________________________

21. Do you wear dentures or have any piercings in your mouth? ___________________________

22. Do you have any problems with urination? ___________________________

23. Do you have any problems with your reproductive organs? ___________________________

24. When was your last menstrual cycle? ___________________________

25. Do you have sleep apnea? ___________ If yes, do you use a CPAP? ___________________________

26. Do you have any problems with walking or moving arms or legs? ___________________________

27. Do you have any problems with skin (rash, open cuts, unhealed sores)? ___________________________

28. Do you have a living will? ___________ Are you an organ donor? ___________________________

29. Are you (please circle one) Married Single Divorced Widow 30. Religion ___________________

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

Home: ___________________ Cell: ___________________ Other: ___________________

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

____

____

____

____

Medication List

Preferred Pharmacy: ____________________

Please list all prescription, herbal and over the counter medications you currently take.

Medicine Name	Dose	How Often	Why do you take this medicine?

IF YOU HAVE A MEDICATION LIST, PLEASE NOTIFY THE STAFF.

BRING ALL MEDICATION BOTTLES WITH YOU ON THE DAY OF YOUR SURGERY/PROCEDURE.