Day Surgery
Health History Form

Rapides Regional Medical Center

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)?

You	Family Member		You	Family Member		You	Family Member		You	Family Member	
☐	☐	Kidney disease	☐	☐	Blood disorder	☐	☐	Epilepsy	☐	☐	Cancer
☐	☐	Heart disease	☐	☐	Asthma	☐	☐	Diabetes	☐	☐	TB
☐	☐	Allergies	☐	☐	Mental disorder	☐	☐	Hepatitis	☐	☐	Lupus
☐	☐	Stroke	☐	☐	High blood pressure	☐	☐	Thyroid problems			

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:

_____

_____

_____