

Please Print:

Patient's full name: _____ Date: _____

first middle initial last

Age: _____ Sex: Male Female Stated height: _____ Stated weight: _____ BMI _____

Home phone: (_____) _____ - _____ Work phone: (_____) _____ - _____

Primary care physician: _____ Phone #: _____

Specialist: _____ Phone #: _____

ALLERGIES: None Yes (include food & latex, list; if yes, describe reaction). _____

MEDICAL / HEALTH HISTORY	given by _____		obtained by _____			<input type="checkbox"/> In person	Phone	
	NO	YES	NO	YES			NO	YES
1. Heart attack/disease	<input type="checkbox"/>	<input type="checkbox"/>	14. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	28. Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
2. Chest pain/pressure	<input type="checkbox"/>	<input type="checkbox"/>	15. Cold in last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>	29. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
3. Irregular heart beat/palpitations	<input type="checkbox"/>	<input type="checkbox"/>	16. Acid reflux/hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>	30. Blood Clots/disorders	<input type="checkbox"/>	<input type="checkbox"/>
4. Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	17. Crohns / Colitis / Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	31. Bruises easily	<input type="checkbox"/>	<input type="checkbox"/>
5. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	18. Hepatitis/jaundice	<input type="checkbox"/>	<input type="checkbox"/>	32. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
6. Pacemaker/AICD	<input type="checkbox"/>	<input type="checkbox"/>	19. Liver disease/cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	33. Neck/back pain	<input type="checkbox"/>	<input type="checkbox"/>
7. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	20. Kidney disease/dialysis	<input type="checkbox"/>	<input type="checkbox"/>	34. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
8. Able to climb 1 flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	21. Peripheral vascular/arterial disease	<input type="checkbox"/>	<input type="checkbox"/>	35. Infectious Disease (C-Diff, HIV, MRSA, VRE)	<input type="checkbox"/>	<input type="checkbox"/>
9. Able to walk 2 city blocks	<input type="checkbox"/>	<input type="checkbox"/>	22. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	36. Malignant Hyperthermia		
10. Asthma/wheezing	<input type="checkbox"/>	<input type="checkbox"/>	23. Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Self Family	<input type="checkbox"/>	<input type="checkbox"/>
11. COPD (emphysema/bronchitis)	<input type="checkbox"/>	<input type="checkbox"/>	24. Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>	37. Any Anesthesia complications		
12. Other lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	25. Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	Self Family	<input type="checkbox"/>	<input type="checkbox"/>
13. Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	26. Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	38. Other Illness/injury	<input type="checkbox"/>	<input type="checkbox"/>
			27. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			

Comments: _____

Previous Endoscopies / Surgery and previous anesthesia: No Yes

SURGERY TYPE	ANESTHESIA PROBLEMS	
	NO	YES
1.	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>

Aspirin, NSAIDS (Motrin / Advil), Coumadin, Plavix, Other blood thinners, No Yes Last Taken: _____

Steroids in last 6 months? No Yes

Do you smoke? No Yes # packs/day? _____ # years smoked: _____ Date quit? _____


Do you drink alcoholic beverages? No Yes How much every day/week? _____

Do you use recreational drugs? No Yes How much every day/week? _____

Females: could you be pregnant? No Yes Date of last menstrual period: _____

Patient/Guardian Signature _____ Date _____ Admitting RN Signature _____ Date _____

Northwest Community Hospital
Northwest Community Hospital Day Surgery Center
 Arlington Heights, IL 60005



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**LOCAL PROCEDURAL SEDATION
 HISTORY & INSTRUCTIONS**

