Pacific Rim OUTPATIENT SURGERY CENTER

Health Status Questionnaire

PATIENT INFORMATION							
Name:				Date of Birth:			Age:
Height:			Weight (lbs):	(kg):			BMI:
SURGICAL PROCEDURE							
DATE OF PROCEDURE/SURGEON							
Date of Surgery:				Surgeon:			
RESPIRATORY							
Shortness of Breath?	No	Yes		Cold or Sore Throat (past 6 weeks)?	No	Yes	
Asthma?	No	Yes		Diagnosed Sleep Apnea? CPAP?	No	Yes	
COPD?	No	Yes		Snoring?	No	Yes	
CARDIOVASCULAR							
High Blood Pressure?	No	Yes		Irregular Heart Rhythm or Murmur?	No	Yes	
Heart Attack or Chest Pain?	No	Yes		Heart surgery and/or procedure?	No	Yes	
Coronary Artery Disease (CAD)?	No	Yes		Pacemaker/ICD?	No	Yes	
Congestive Heart Failure?	No	Yes		Phlebitis/Blood Clots?	No	Yes	
NEUROLOGICAL/PSYCHIATRIC							
Seizures?	No	Yes		Other Neurological Conditions?	No	Yes	
Stroke/TIA?	No	Yes		Depression/Anxiety/Psychiatric Illness?	No	Yes	
MUSCULOSKELETAL							
Difficulty with neck mobility?	No	Yes		Trouble lying flat?	No	Yes	
TMJ/Difficulty opening mouth?	No	Yes		Need assisted devices for mobility?	No	Yes	
GASTROINTESTINAL							
Swallowing Problems?	No	Yes		Peptic Ulcers?	No	Yes	
Hiatal Hernia/Heartburn/Reflux?	No	Yes		Liver Problems?	No	Yes	
GENITOURINARY							
Kidney/Urinary Tract Problems?	No	Yes		**Women -** Hysterectomy?	No	Yes	
Men - Prostate Problems?	No	Yes		**Women** - Pregnant?	No	Yes	
ENDOCRINE							
Diabetes?	No	Yes	How long?	Last A1C=	Treatment?		
Thyroid Condition?	No	Yes					
HEMATOLOGIC/IMMUNE							
Blood Disorders?	No	Yes		Autoimmune Disorders?	No	Yes	
GENERAL HEALTH							
Diagnosed with cancer?	No	Yes	Type?	When?	Treatment?		
MRSA or VRE?	No	Yes		Other health issues not yet discussed?	No	Yes	
HABITS							
Caffeine?	No	Yes	Amount/How often?				
Alcohol?	No	Yes	Amount/How often?				
Smoking History?	No	Yes	Cigarettes per day?	Years?		☐	Quit--Year:
Recreational drugs?	No	Yes	Type?	How often?			
History of drug/alcohol abuse?	No	Yes	When?				
PEDIATRIC PATIENTS							
Full term birth?	No	Yes		Complications with pregnancy/delivery?	No	Yes	
Current on all vaccinations?	No	Yes					

NOTES

PATIENT LABEL

ALLERGIES/SENSITIVITIES							
☐ No Known Allergies ☐ Allergies (please write reactions to all listed allergies):							
Latex?	No	Yes		Soy?	No	Yes	
Tape?	No	Yes		Eggs?	No	Yes	
Iodine?	No	Yes		Other food?	No	Yes	
Shellfish?	No	Yes					

CURRENT PRESCRIPTION MEDICATION, OVER-THE-COUNTER DRUGS, SUPPLEMENTS			
☐ See attached medication list	☐ Prescription-None	☐ OTC/Supplements-None	☐ Pt cannot recall dosages/frequency

PREVIOUS SURGERIES/ DATES

Has the patient or a patient family member ever had a problem with anesthesia?	No	Yes	If yes, describe the problem:

OTHER PHYSICIAN INFORMATION

PATIENT ESCORT	
☐ PROSC post-op escort and caregiver requirement explained	
Name of person driving the patient home after surgery?	
Name of person caring for the patient after surgery?	Same ☐

ADVANCE DIRECTIVES			
Advance Directives?	No	Yes	☐ PROSC advance directives policy explained

PRE-OP INSTRUCTIONS		
☐ Pre-operative instructions discussed with patient/patient representative	☐ Questions answered	☐ Health Questionnaire done DOS

ANESTHESIA CONSULT			
Does this patient require a consult?	No	Yes	Why?:

NURSE SIGNATURE/REVIEW DATE		
Nurse Signature:	Date :	Time:

Interview Conducted: ☐ by phone ☐ in person ☐ by interpreter; name____________________

Interview Conducted With: ☐ patient ☐ parent /legal guardian; name_________________________ ☐ other:____

NOTES

PATIENT LABEL