COLUMBIA SURGERY CENTER, INC.

HEALTH HISTORY

Name_____ Date_____

Date of birth_____ Age_____ Hgt_____ Wgt_____

Insurance_____ County _____

Name, Address and Phone Number of Primary Care Provider _____
_____
_____

Do you smoke: Yes_____ No_____How many per day_____ How many years_____

Do you drink alcohol: Yes_____No_____ How much_____ Everyday_____

Allergies:_____

Allergic reactions: Rash_____ Hives_____ Shortness of breath_____ Other_____

Current Medications:

Name of medications	Amount (dosage)	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____

list others on back of form

PLEASE CIRCLE THOSE THAT APPLY

Do you have a history of:

Recent cold	Loose teeth	Swollen ankles
Hayfever	Dentures	Chronic cough
Back pain	Epilepsy or seizures	Shortness of breath
Painful joints	Diabetes	High blood pressure
Pneumonia	Thyroid disease	Hepatitis
Tuberculosis	Asthma	Cirrhosis
Emphysema	Stroke	Paralysis
Bronchitis	Anemia	Kidney stones
Heart attack	Ulcer	Liver disease
Angina/chest pain	Hiatal hernia	Jaundice
Heart failure	Kidney disease	COPD
Irregular heart beat	Bladder trouble	Arthritis
Pacemaker	Cancer or tumor	Fainting/dizziness
Sexual or blood transmitted diseases	Sickle cell anemia	Prolonged bleeding

Have you or any member of your family had an unusual reaction to anesthesia? Y N
What happened: _____

Have you had surgery before? Yes_____ No_____
If yes, please list_____

Patient Signature_____ Date_____

Reviewed with patient (signature) _____ _____