CAMPUS SURGERY CENTER
901 Campus Drive, Suite 102 ♦ Daly City, California 94015 ♦ (650) 991-2000 ♦ Fax (408) 402-7016

Patient Sticker Here
Name
DOS

PATIENT HEALTH HISTORY

Patient Name____

Age ____ Height____ ft. ____in. Weight _____lbs. BMI______

Cell Phone # (_____)_______________ Home/Alternate # (_____)_______________ Male ☐ Female ☐

Language Spoken ________________________ Email Address__________________________@___________________

Planned Procedure ____Right ☐ Left ☐ Both ☐ N/A ☐

Surgeon: _____________________ Medical Doctor:__________________________ Cardiologist:_________________________

List all previous surgeries and procedures (even childhood ones, colonoscopies and vaginal deliveries)

PAST SURGERIES OR PROCEDURES TYPE OF ANESTHESIA YEAR

☐ None

____
____
____
____
____
____
____

☐ N ☐ Y Have you been to Campus Surgery Center before? When?_____________

☐ N ☐ Y Did you have any problems with any anesthetics? Has anyone in your family had trouble with anesthesia?

____
____
____

☐ N ☐ Y Have you **EVER** smoked?
If **yes**, how old were you when you started?______ How much did you smoke on a regular basis? _____ packs per day.
If you quit, when did you quit? _______years ago

☐ N ☐ Y Do you drink alcohol? If **yes**, how many drinks can you drink without feeling a little drunk? _______

☐ N ☐ Y Do you presently use any recreational drugs? If **yes**, please list _____________________________

☐ N ☐ Y If you are a woman, is there ***ANY*** chance you may be pregnant? Date of last menstrual period______
Post-menopause_____

Significant medical history: Check for any condition that **you** have had personally (***NOT*** family members)

Please check all that apply

1. ☐ N ☐ Y **Neurological** (strokes, seizures, black-out spells, anxiety, depression, insomnia, migraines, severe headaches)
2. ☐ N ☐ Y **Eyes/Ears** (glaucoma, visual loss, hearing loss, vertigo, tinnitus, ear infections)
3. ☐ N ☐ Y **Respiratory** (sinusitis, hayfever, asthma, TB, recent colds, cough, shortness of breath, snoring, sleep apnea)
4. ☐ N ☐ Y **GI** (heartburn, reflux, hiatal hernia, gastritis, ulcers, irritable bowel, diverticulosis, constipation, hemorrhoids)
5. ☐ N ☐ Y **Cardiac** (high cholesterol, chest pain, atrial fib, arrhythmias, palpitations, rheumatic heart, heart murmurs, mitral valve prolapse, heart failure, heart attack, coronary stents, hypertension)
6. ☐ N ☐ Y **Endocrine** (thyroid imbalance, goiter, parathyroid imbalance, diabetes or pre-diabetes)
7. ☐ N ☐ Y **GU** (kidney disease, kidney infections, bladder infections, kidney stones, prostate disease)
8. ☐ N ☐ Y **Liver/HIV** (hepatitis, jaundice, mononucleosis, HIV Positive)
9. ☐ N ☐ Y **Blood** (anemia, thalassemia, sickle cell, bleeding disorders, deep vein thrombosis, blood transfusions)
10. ☐ N ☐ Y **Musculoskeletal** (arthritis, rheumatoid, psoriatic, gout, neck pain, back pain, sciatic)

____
____

NONE OF THE ABOVE ☐

☐ N ☐ Y Do you wear contact lenses?

☐ N ☐ Y Do you have any caps, veneers or crowns, bridges or dentures?
Where?_______________________________________

N Y Refer to Medical Director
Date/time:_____________ **Doctor**_______________
Notified of: ________________________________
____
____
MD signature________________________________
N Y Case to Proceed

Patient Sticker Here
Name
DOS

LIST OF MEDICATIONS

(Note: if being completed by patient, leave shaded areas blank)

Allergies: (Include all drugs, foods, and environmental allergies)

☐ No known allergies

Allergy	Type of Reaction	Allergy	Type of Reaction
		☐ N ☐ Y Latex Allergy	
		☐ N ☐ Y Iodine Allergy	

Medications: (Include all prescriptions, over-the counter medicines, supplements, and herbs)
☐ No current medications

Current Prescription Medications:	Dose	Last Dose Taken/Time	How Often	Stop After Discharge
Herbals, Vitamins, Supplements, Non-Rx Drugs	**Dose**	**Last Dose Taken/Time**	**How Often**	**Stop After Discharge**

☐ For additional Medications see separate sheet

Patient/Responsible Person Signature: ____________________________ **Date:** _____________

Pre-op Caller that Collected History: ______________________________ Date: _____________

☐ NA New Medications or New Dosages for After Discharge	Dose	How Often

Patient/Responsible Person Signature: _____________________________ Date: ____________

Discharge Nurse Signature: _____________________________________ Date: ____________

Resume Pre-Operative Medications as directed by the prescribing Physician. Any Medications that need to be stopped after discharge are noted above.

Practitioner's Signature: ____ **Date:** ___________