

# MEDICAL INFORMATION QUESTIONNAIRE

The accuracy of this information is important to the safety of your care.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Stated Height: \_\_\_\_\_ Stated Weight: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Interpreter Needed?  YES  NO For which language? \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #'s Home ( ) \_\_\_\_\_ Wk ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Internist: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Cardiologist: \_\_\_\_\_ Last Seen: \_\_\_\_\_

**ALLERGIES and ALLERGIC REACTIONS:**

Allergic to: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Food: \_\_\_\_\_

\_\_\_\_\_

Tape  Latex: \_\_\_\_\_

Other: \_\_\_\_\_

**LIST PREVIOUS SURGERIES:**      Year      Complications      Type of Anesthesia

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please check if you have had any of the following CARDIAC/MEDICAL procedures:**

Procedure      Year      Where test/procedure done

\*\* Angioplasty/Stent Placement (Type- Bare Metal  Drug eluting)

Echocardiogram

Stress Test

\*\* Pacemaker/Defibrillator (model/brand #)

Other, please specify: \_\_\_\_\_

**Please check if you have been told you have any of the following health issues:**

Hypertension (> 50 yrs/>160/100 – EKG)      \*\*  Heart Valve Problems (EKG)       High Cholesterol

\*\*  Heart Attack- Date: \_\_\_\_\_ (EKG/CXR)       Heart Murmur       Poor Circulation in

Coronary Artery Disease       Carotid Artery Disease      lower extremities

Family History of Heart Disease      \*\*  Cardiomyopathy

\*\*  Angina/Chest Pain – Date \_\_\_\_\_ Recent EKG      \*\*  Congestive Heart Failure       Pain or shortness of

\*\*  Arrhythmias, i.e., A-Fib      \*\*  Open Heart Surgery      breath when walking 2

Rheumatic Fever       Recent chest trauma      blocks or climbing 1

flight of stairs.

**\*\*SURGEON- Consider Cardiac Consult for yes to any \*\* (asterisk) symptoms prior to Pre-Op Appt**

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**Please check if you have been told you have any of the following health issues:**

<p><b><u>PULMONARY</u></b> (o2 sat&lt;95% on RA- CXR)</p> <input type="checkbox"/> Recent cold or Flu <input type="checkbox"/> Asthma <input type="checkbox"/> COPD/Bronchitis/ Emphysema (CXR) <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis Treated/Untreated(CXR) <input type="checkbox"/> Blood clots in lung or legs <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> CPAP (Bring Machine) <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Oxygen Use ___ liters	<p><b><u>GASTROINTESTINAL</u></b></p> <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Ulcers <input type="checkbox"/> GERD <input type="checkbox"/> Gastric Reflux <input type="checkbox"/> Diverticulosis <input type="checkbox"/> IBS <input type="checkbox"/> GI Bleed <input type="checkbox"/> Gallstones <input type="checkbox"/> Liver Disease * <input type="checkbox"/> Hepatitis A, B, or C * * (SGOT/PT/PTT) <b><u>VASCULAR</u></b> <input type="checkbox"/> Lupus <input type="checkbox"/> Raynauds <input type="checkbox"/> Aneurysm	<p><b><u>GENITOURINARY</u></b></p> <input type="checkbox"/> Urinary Tract Infections <input type="checkbox"/> Kidney Stones * <input type="checkbox"/> Prostate Disease <input type="checkbox"/> Penile Prosthesis <input type="checkbox"/> Dialysis * <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Transplant * <input type="checkbox"/> Blood/protein in urine *  * K+/BUN/CR	<p><b><u>ORTHOPEDIC/PAIN</u></b></p> <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Chronic Pain Source: _____ Treatment _____ <input type="checkbox"/> Back pain <input type="checkbox"/> Neck Pain <input type="checkbox"/> Artificial Joints Location: _____ _____ Date: _____ <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Jaw pain/TMJ
<p><b><u>HEMATOLOGIC</u></b> (CBC)</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Blood Diseases, i.e., Leukemia <input type="checkbox"/> Blood Transfusions <input type="checkbox"/> Easy Bruising <input type="checkbox"/> History Of Blood Clot <input type="checkbox"/> Taking Anticoagulants (Blood Thinners)	<p><b><u>ENDOCRINE</u></b></p> <input type="checkbox"/> Diabetes (BS) <input type="checkbox"/> Hypo/Hyperthyroidism <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Adrenal problems (BS) <input type="checkbox"/> Insulin pump <input type="checkbox"/> Steroid/Prednisone use	<p><b><u>NEUROLOGIC</u></b></p> <input type="checkbox"/> Stroke/mini stroke Date: _____ <input type="checkbox"/> Seizures (if taking Phenobarbital, Tegretol, Dilantin, or Depakote draw levels the day of surgery) <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Paralysis <input type="checkbox"/> Muscle Weakness	<p><b><u>NEUROLOGIC cont.</u></b></p> <input type="checkbox"/> Headache/Migraines <input type="checkbox"/> Fainting <input type="checkbox"/> Numbness/ tingling <input type="checkbox"/> Neuropathy <input type="checkbox"/> Parkinsons
<p><b><u>INFECTIOUS DISEASE</u></b></p> <input type="checkbox"/> MRSA Location _____ Cleared: By: _____ Date _____ <input type="checkbox"/> VRE <input type="checkbox"/> C. Diff <input type="checkbox"/> Acinetobacter <input type="checkbox"/> Current Diarrhea	<p><b><u>PSYCHIATRIC</u></b></p> <input type="checkbox"/> Dementia <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Psychosis <input type="checkbox"/> Depression <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Anxiety/ panic attacks <input type="checkbox"/> Bipolar/mood swings	<p><b><u>PEDIATRICS (&lt;13YRS)</u></b></p> <input type="checkbox"/> Normal Growth and Development <input type="checkbox"/> Loose Teeth <input type="checkbox"/> NICU at Birth <input type="checkbox"/> Frequent Fever/Infections <input type="checkbox"/> Prior Hospitalization <input type="checkbox"/> Days Hospitalized at Birth _____ <input type="checkbox"/> Immunizations Current	<p><b><u>GYN( Female only)</u></b></p> <input type="checkbox"/> Date of Last menstrual Cycle _____ (HCG) <input type="checkbox"/> Menopause <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Currently Pregnant <input type="checkbox"/> Preeclampsia <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Placenta Abruption or Detachment <input type="checkbox"/> Pregnancy Induced Hypertension or Toxemia <input type="checkbox"/> Twins/Breech Delivery

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Patient Name: \_\_\_\_\_

**Please check appropriate box in each section below:**

**GENERAL HEALTHCARE**

	YES	NO
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Location: _____		
Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>

**Social History:**

	YES	NO
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Amount: _____		
Do you smoke? Packs/day _____	<input type="checkbox"/>	<input type="checkbox"/>
Did you ever smoke? Year's _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you smoked in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____		

Have you had:	YES	NO
Flu Vaccine – Date _____	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia Vaccine – Year _____	<input type="checkbox"/>	<input type="checkbox"/>
TB Skin Test	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		

	YES	NO
History of Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>
Family history of anesthesia problems or MH (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Post-op Nausea/ Vomiting	<input type="checkbox"/>	<input type="checkbox"/>

**SURGICAL INFORMATION:**

Do you have any specific needs?	YES	NO
Hearing      Left __ Right __	<input type="checkbox"/>	<input type="checkbox"/>
Vision cataracts Left __ Right __	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma      Left __ Right __	<input type="checkbox"/>	<input type="checkbox"/>
Legally Blind   Left __ Right __	<input type="checkbox"/>	<input type="checkbox"/>
Walk independently	<input type="checkbox"/>	<input type="checkbox"/>
Walking Assistance needed	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Partial <input type="checkbox"/> Total		
<input type="checkbox"/> Cane <input type="checkbox"/> Walker		

**Skin :**

	YES	NO
Rash	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Scabies	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have caps, bridges, dentures, or loose teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you refuse blood transfusions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you donated blood for this operation?	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_  
(Patient/Parent/Conservator/Guardian)      (Date)      (Time)      (If completed by other than patient, indicate relationship)

\_\_\_\_\_  
(Reviewed and entered into ICIS by Pre-op Nurse)      (Date)      (Time)