POMONA VALLEY HOSPITAL
MEDICAL CENTER

Expert care with a personal touch

PREADMISSION TESTING HEALTH HISTORY

To Be Completed by the Patient

Patient Name _____ Date of Birth _____

Telephone #: Cellular: _____ Work: _____ Email: _____

Your surgeon's name: _____ Reason for surgery: _____

Person responsible for you on day of surgery: _____ Phone: _____

THIS PERSON WILL TRANSPORT ME HOME AFTER SURGERY – initial here: _____

My Healthcare Power of Attorney: _____; I don't have one: _____ initials

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General: My weight: _____ My height: _____ feet _____ inches

My recent (< 1 year) foreign travel (and when): _____

Medicines I cannot take and why: _____

My pharmacy name and number_____

I am allergic to Latex: No Yes **Other things I don't tolerate: _____**

Health aids I use (circle): Wheelchair Walker Cane Glasses Contacts Hearing Aids Dentures

It is possible that I could be pregnant: No Yes Applicable

I'm scared about my surgery for the following reasons: _____

My Medical Problems: _____

_____

_____

My Medical Doctors: _____

Health/medical problems that I have (circle if yes): Please explain

Neurological/Nervous system (Headaches, Seizures, Strokes):

Respiratory/Lungs (Asthma, Emphysema, Oxygen use):

Liver (Hepatitis, cirrhosis):

Diabetes (describe any insulin or treatment):

Thyroid:

Pancreas (Pancreatitis):

Psychiatry (Depression, Drug problems):

Heart or Circulation (High Blood Pressure, Heart Attack):

Do you have a cardiologist? _____

Stomach or Colon (Heartburn, ulcers, Crohn's):

Kidney:

Genitals or urination:

Skin (rashes, sores):

Muscle or joints (rheumatoid arthritis, amputations):

Others (Please explain):

My previous surgeries: _____

_____

_____ Initial here if no previous surgery _____

My problems with surgeries (e.g. pain, vomiting): _____

My problems with anesthesia: _____

Have you or a family member been diagnosed with Malignant Hyperthermia: Yes/No

My previous blood transfusions (date): _____ Initial here if no transfusions: _____

My problems with blood transfusions: _____

Do you take blood thinners? _____

Vaccines: Influenza - _____ (last date given) Tetanus _____ (last date given)

Pneumonia - _____ (last date given) Hepatitis B _____ (last date given)

Chicken Pox/Varicella - _____ (date given) Other - _____

I have sleep apnea: Yes No **I use CPAP or another device:** Yes No **I will bring my machine** Yes No

_____ I Snore loudly ____ I feel tired in daytime ____ Someone has seen me stop breathing

_____ I have high blood pressure _____ I'm overweight _____ is my neck size

_____ I want someone to talk to me about these and how it may impact my surgery

I still smoke tobacco: No Yes **How much? Last use: _____**

I use caffeine: No Yes **How much? _____ Last use: _____**

I use cannabis or marijuana: No Yes **How much? _____Last use: _____**

I drink alcohol: No Yes **How Much? _____ Last use: _____**

I have used an illegal drug in the past year: No Yes **Which one? _____**

I use vitamins, supplements, or other meds: _____

Family History: Mother_____Father_____

_____ _____ _____

Person Filling This Out **Relation to Patient** **Today's Date**