Greater Erie Surgery Center, LLC

PATIENT HEALTH ASSESSMENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Daytime phone: _____ Home phone: _____ Family Doctor: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Do you have a living will? ☐ Yes ☐ No Placed on chart? ☐ Yes ☐ No ☐ N/A Email_____

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Height: _____ **Weight:** _____

Do you or have you had any of the following:

Allergy:_____

Cardiac (Heart) History:

Chest pain	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No
Coronary Artery Disease	☐ Yes ☐ No
Congestive Heart Failure	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No
Valve Replacement	☐ Yes ☐ No
Implanted Defibrillator	☐ Yes ☐ No
Irregular Rhythm	☐ Yes ☐ No
Murmur	☐ Yes ☐ No

Pulmonary (Lung) History:

Asthma	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No
Sleep Apnea/CPAP	☐ Yes ☐ No
COPD	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
Cough/Cold	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No
Tobacco use	☐ Yes ☐ No

What: _____ How much? _____

Gastrointestinal (GI) History:

Reflux/GERD	☐ Yes ☐ No
Ulcer	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No
Jaundice	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No
Hiatal Hernia	☐ Yes ☐ No

Endocrine History:

Diabetes	☐ Yes ☐ No
Thyroid	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No

Musculoskeletal History:

Arthritis	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No
Hip/joint Replacement	☐ Yes ☐ No

Genital-Urinary (GU) History:

Renal failure	☐ Yes ☐ No
Dialysis	☐ Yes ☐ No
Urinary Tract Infections	☐ Yes ☐ No
Menopause	☐ Yes ☐ No
Pregnant	☐ Yes ☐ No

Infectious Diseases:

HIV/AIDS	☐ Yes ☐ No
MRSA	☐ Yes ☐ No

Psychological:

Depression	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No
Bipolar	☐ Yes ☐ No
Alzheimer	☐ Yes ☐ No

Other:

Alcohol	☐ Yes ☐ No
What? _____ How much? _____	
Street Drugs	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Dental problems	☐ Yes ☐ No
Hearing problems	☐ Yes ☐ No
Visual problems	☐ Yes ☐ No
Epilepsy/Seizure	☐ Yes ☐ No

Past Surgeries: _____

Any problems with anesthesia? ☐ Yes ☐ No ☐ Self ☐ Family member, _____

Patient Signature: _____ Date: _____ Time: _____

Nurse Signature : _____ Date: _____ Time: _____

Updated by: _____ Date: _____ Time: _____

Updated by: _____ Date: _____ Time: _____

Updated by: _____ Date: _____ Time: _____

Updated by: _____ Date: _____ Time: _____