LOVEJOY surgicenter

PATIENT HEALTH HISTORY

Medical staff	
Date	
MR #	
NPO SINCE	
BMI	

Name: _____ Date of Birth: _____

Age:_____ Height:_____ Weight:_____

Last Menstrual Period: Date: _____ Unknown □

Drug allergies: _____

Food allergies: _____

Current medications: _____

PREGNANCY HISTORY:

	No	Yes	Where	When
Have you had a positive pregnancy test?				
Have you had a physician exam during this pregnancy?				
Have you had an ultrasound during this pregnancy?				
How far into the pregnancy were you?	Weeks:			

Do you currently have an IUD in place?			
Are you currently breast feeding?			
Were you using birth control when you became pregnant?			Type:

PREVIOUS PREGNANCIES:

	Yes	No
Have you had a blood transfusion?		
Number of Miscarriages		
Was a D&C performed?		
Complications		
Number of Abortions		
Were they at Lovejoy Surgi center?		
Complications		

Total number of:	
Pregnancies	
Cesarean sections	
Vaginal deliveries	

GYNECOLOGIC HISTORY:

Do you have normal menstrual periods? Yes □ No □

At what age did you begin menstruation? _____

Date of last Pap smear: _____ Was it normal? Yes □ No □

Have you ever had an abnormal Pap smear? Yes □ No □ If yes, what was the treatment? _____

What birth control methods have you used in the past? Please circle all that apply:

Rhythm	Suppositories
Pills	Sponge
Diaphragm	IUD
Condoms	Cervical Cap
Foam	Depo Provera Injection
Nexplanon Implant	

What method are you requesting for the future?

_____

Do you have any history of?

	NO	YES	Dates and Treatment
Syphilis			
Chlamydia			
Herpes			
Gonorrhea			
PID (Pelvic Inflammatory Disease)			
Ovarian Cysts			
Other female organs diseases			
Abnormal mamograms			
Breast tumors / other breast problems			

FAMILY HEALTH HISTORY:
Please circle all that apply:

Sudden Death	Stroke	Heart Disease
Malignant hyperthermia (high fever during surgery)	Musle weakness after surgery	

SOCIAL HISTORY:

Have you ever sought professional counseling, including abuse and/or drug/alcohol rehabilitation? No □ Yes specify:

_____

Are you currently in an emotional or physically abusive relationship? Yes □ No □

If yes, do you want to talk about it? Yes □ No □

Do you need resources? Yes □ No □

REVIEW OF SYSTEMS: Please circle all that are applicable (within the last 6-12 months)

CONSTITUTIONAL		
Fever	Feeling poorly/weak	Recent weight gain
Chills	Feeling tired	Recent weight loss

CARDIOVASCULAR	
Chest pain	Abnormal heart rate
Palpitations	Leg swelling

RESPIRATORY
Any shortness of breath
Wheezing
Cough

GASTROINTESTINAL	
Abdominal pain	Heartburn
Nausea/Vomiting	Black stool
Diarrhea	Constipation

URINARY	
Increase urinary frequency	Blood in urine
Incontinence	Cloudy / odor in urine
Problems emptying bladder	Kidney stones

MUSCULOSKELETAL	
Limb pain	Joint swelling
Joint stiffness	Limb swelling

HEMATOLOGY/IMMUNOLOGY	
Easy bleeding	Swollen glands
Easing bruising	Seasonal Allergies

PSYCHIATRIC
Anxiety
Depression
Feeling Suicidal / Attempts

ENDOCRINE
Hair loss
Hot flashes
Heat/Cold intolerance

OBGYN		
Abnormal bleeding	Vulvar itching / Pain	Vaginal itching
Irregular menses	Midcycle bleeding	Pelvic pain
Pain with menses	Pain with intercourse	Vaginal odor

PAST MEDICAL HISTORY:

	No	Yes	Specify
Heart Murmur			
High Blood Pressure			
Blood clots in legs or lungs			
Asthma			
Smoking			
Recent cold			
Sleep Apnea			
Acid reflux			
Nausea / vomiting			
Stomach ulcers			
Hepatitis			
Liver Disease			
Kidney Disease			
Bladder / kidney Infection			

	No	Yes	Specify
Thyroid disease			
Diabetes			
Migraine Headaches			
Stroke			
Neurologic Disorders			
Anxiety / depression			
Other psychiatric disorders			
Convulsions, seizures or epilepsy			
Black out spells or fainting			
Broken bones in the face, neck or back			
Temporal-mandibular Joint Disorder			
HIV/AIDS			
Bleeding Abnormalities			
MRSA			

SURGICAL HISTORY:

	No	Yes - List
Have you had surgery?		
Have you ever been admitted to the hospital?		
Have you have any recent emergency room visits?		

ANESTHESIA HISTORY. CIRCLE ALL THAT APPLY

Difficult airway	Difficulty waking
Malignant hyperthermia	Extreme sore throat / dental damage
Muscle weakness after surgery	Anaphylaxis
Extreme nausea / vomiting	

NO COMPLICATIONS ☐

SUBSTANCE USE:

WHEN DID YOU LAST USE?

	Date used	Date quit	NA
Cigarettes			
Alcohol			
Opiate pain medications			
Marijuana			
Heroin			
Methamphetamine			
Cocaine			
Methadone			
Suboxone			

OTHER

Do you wear contacts? Yes ☐ No ☐ Out today ☐

Do you have any teeth that are: Chipped ☐ Loose ☐ Removable ☐

Do you have any piercings: Tongue ☐ Face ☐ Back ☐ Other ☐

Patient Signature Date Time

Counselor Signature Date Time

Physician Signature Date Time

Anesthesia Provider Signature Date Time