jacksonville beach Surgery Center

Patient Name: _____

Respiratory or Breathing Problems

Yes No Have you ever smoked? Packs per day? _____ How many years? _____ When did you quit? _____
Yes No "Wheezing", COPD (Emphysema, chronic bronchitis) or Asthma?
Yes* No Do you use oxygen at home?
Yes* No Have you visited the emergency room for breathing problems in the past 2 years?
Yes* No Upper respiratory infection or new productive cough within the past week?
Yes* No Sleep apnea? If so, do you use CPAP to sleep? Yes_____Is CPAP functional/available?_____
No_____ Reason?_____
Yes No TB? Treated?

Neurologic Problems

Yes No Stroke (CVA) or mini-stroke (TIA)? If yes, when? _____Residual?_____
Yes No Seizures or epilepsy? If yes, when was your last seizure? _____
Yes No Neck pain and/or back pain?
Yes No Peripheral neuropathy (numbness or tingling in hands, arms, feet, or legs)?

Endocrine or Metabolic Problems

Yes No Diabetes?
Yes No Thyroid disease?
Yes No Have you taken steroids *within the last year* to treat breathing problems or arthritis?

Gastrointestinal or Liver Problems

Yes No Inflammatory bowel disease (Crohn's or Ulcerative colitis)?
Yes No Hiatal hernia, GERD (gastroesophageal reflux disease) or peptic ulcer disease?
Yes* No Cirrhosis of the liver?
Yes No Hepatitis B or C?

Kidney Problems

Yes* No Kidney failure requiring dialysis? If yes, what days of the week do you receive dialysis? _____
Last labs?_____

Blood Problems

Yes No Anemia (low red blood cells)?
Yes* No Thrombocytopenia (low platelet count)?
Yes* No Blood clotting problems or excessive bleeding (Hemophilia, von Willebrand's disease)?
Yes No Sickle cell disease or trait?
Yes No Deep venous thrombosis (DVT) or pulmonary embolism (PE)?
Yes* No Do you take any blood thinners (anticoagulants)?
Yes No HIV/AIDS?

Anesthesia Problems

Yes* No Do you have a personal or family history of malignant hyperthermia?
Yes* No Told that it was difficult to place a breathing tube in your airway (intubation)?
Yes* No Had severe nausea/vomiting or other severe reaction after anesthesia?

Other

Yes No Cancer? If yes, what kind? _____(*Head/Neck) Chemotherapy or radiation? If yes, when? _____
Yes No Do you refuse to receive a blood transfusion if medically necessary?
Yes No Rheumatoid arthritis, Lupus or other autoimmune disease?
Yes No Is there a possibility you may be pregnant? Date of last menstrual period _____
Yes No Do you drink alcoholic beverages? Average number of drinks per week _____
Yes No Have you been diagnosed with C.Diff/MRSA?
Yes No Travel out of the country? When?_____Where?_____
Yes No Is there anything else about your medical history not mentioned above? If yes, please describe:

_____

_____