SURGICENTER OF GLEN BURNIE, LLC

Patient Label

Medical History Questionnaire

Name: _____ Surgeon: _____

Escort: _____ Procedure: _____

Height: _____ Weight: _____ Pain score today: _____ out of 10

Allergies: _____ Date of last Center visit: ____/____/_____ ☐N/A

Any Changes in Medical History since your last visit?

☐YES (please complete form) ☐ NO Patient signature _____

Please list all the medications you are taking (over the counter included) and the last time of day you took them: **☐ see attached med list**

Medication	Last dose	Medication	Last dose	Medication	Last dose

Please list all previous surgeries and hospitalizations:

Date	Medical Condition/Surgery	Date	Medical Condition/Surgery

Please check whether you have any of these conditions:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Irregular Heartbeat/ Arrhythmias			Alcohol or recreational drug use			Problems w/Anesthesia?		
Chest Pain			Diabetes			Family history w/anes.		
High blood pressure			Hyperthyroidism					
Low blood pressure			Hypothyroidism			Stroke		
Heart Attack			Other Thyroid prob			Seizures		
Heart murmur			Gastric reflux			Parkinson's Disease		
Heart catheterization			Ulcers			Other neuro problems		
Valve replacement			Hiatal hernia			MRSA/Staph infection		
Other Heart problems			Other GI problems			TB		
COPD						HIV or AIDS		
Asthma/ Allergies			Depression/BiPolar			Hepatitis		
Chronic cough			Psychiatric Disorders			Other infectious prob		
Sleep Apnea			Anemia					
Shortness of breath			Excessive bleeding					
Other respiratory prob			Other bleeding disorders			Urinary or Kidney Disorders		
Smoker packs per day ____x ____years			Any other conditions??			Special needs: wheelchair, cane, etc...		

Completed by: Reviewed by:

_____ _____ _____ _____

Patient signature Date Nurse signature Date