San Joaquin Laser and Surgery Center

Health History Questionnaire

Name: _____ **M / F** Age:_____ Wt:_____ Ht:_____
Date of Birth(*dd/mm/yyyy*): ___/____/_____

Do you wear? *(Circle one)*
Contacts: Y N Left/Right/Both **Dentures:** Y N **Hearing Aids**: Y N Left/Right/Both

Allergies to Medications: _____
(Please list) _____
Allergies to Foods, Tape, Soap, LATEX, etc: _____
(Please list)
Who will take you home? _____Relationship:_____Phone#_____

Current Medications – (*please attach list if necessary)*

Medication	Dose/Mg	X per day	Medication	Dose/Mg	X per day
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Have you or a blood relative ever had a complication with anesthesia? ☐ Yes ☐ No
describe_____

List any Previous Surgeries and the dates or years of the surgeries: _____
_____
_____
_____

Medical History *(Check all that apply to you)*

Cardiac	**Lungs**	**Thyroid**
☐ Angina/Chest Pain ☐ Congestive Heart Failure ☐ Irreg. Heart Beats ☐ Coronary Bypass #_ ☐ High Blood Pressure ☐ Pacemaker	☐ Asthma/Use Inhalers ☐ Emphysema ☐ COPD/Use Oxygen at home? ☐ Bronchitis ☐ Allergies ☐ Sleep Apnea/Wear CPAP? ☐ Smoker, Pks per Day	☐ Hyperthyroid ☐ Hypothyroid **Eyes** ☐ Glaucoma ☐ Cataract surgery ☐ Retina surgery
Kidney	**Liver**	**Diabetics**
☐ Chronic Urinary Tract Inf. ☐ Dialysis, When_____ ☐ Voiding at Night #_____	☐ Hepatitis A,B,or C ☐ Cirrhosis	☐ Oral Meds ☐ Insulin Reg/NPH ☐ Diet Controlled
Central Nervous System	**Pregnancy Screening**	**Other**
☐ Stroke/TIA's ☐ Seizures/Migraines	☐ Possibility that you might be pregnant? If yes, please speak with surgeon and staff.	☐ Alcohol Use How Often_____ ☐ Drug Use Specify_____ ☐ Bleeding Disorder ☐ History of Mental Illness ☐ **Take/Have taken FLOMAX**

Patient/Guardian Signature:_____ **Date**_____