# HEALTH QUESTIONNAIRE

Instructions: Please complete this Health Questionnaire and bring it with you to the hospital.

Name:_____ Height_____ Weight_____Date of Surgery:_____

Allergies to Medications:_____

Allergies to Food/Environmental:_____

Comments

1.
2.
3.
4.
5.
6.
7.

| Home Medications<br>(Include prescription, non- prescription, herbal and vitamin supplements) | | | |
|---|---|---|---|
| Medication Name | Dose | Route | Frequency |
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Would you accept a blood transfusion if medically necessary? _____

Nutritional Services Screen: Are you currently on a special diet? _____

Exercise screen: What kind of exercise do you do? _____

Have you had a flu vaccine in the past year? …No …Yes Date: _____
Have you had a pneumococcal vaccine within the last 5 years?.No …Yes Date: _____
Year of last tetanus vaccine: _____ Year of TB skin test? _____ …Positive …Negative
Do you have a history of infectious disease (MRSA, TB, Hepatitis) _____

Do you have an Advance Directive?…No …Yes
…Living Will …Medical durable power of attorney …Other _____
Does the hospital have a copy? …No …Yes

Do you have thoughts of harming yourself or others…No …Yes
Do you have a history of substance abuse (drugs/Alcohol).No …Yes Date of last use? _____
Do you live in a safe environment? _____

Form Completed by: _____ Date: _____

Reviewed by: _____ RN Date: _____ Time: _____

PATIENT ID