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.		No	
2.		No	
3.		No	
4.		No	
5.		No	
6.			
7.			
Cancer?			

Stroke?

Heart Problems (e.g. heart failure, Irregular beats, etc.)?

Cardiologist

Pacemaker? AICD? If yes, name of company?

High blood pressure?

Liver problems (e.g. hepatitis, cirrhosis)?

Kidney or urinary problems (e.g. kidney failure or stones, enlarged prostate)?

Could you be pregnant? Date last menstrual period:

Pregnancy test refused: ...Signature

Stomach problems (e.g. acid reflux, ulcers, etc.)

Bowel Problems (e.g. constipation, irritable bowel, etc.)

Emotional Problems (anxiety, depression, bipolar, etc.)

Dizzy spells/fainting?

Castle Medical Centerailua, Hawaii PATIENT ID

HEALTH QUESTIONNAIRE

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PATIENT QUESTIONNAIRE

FORM 1835 REV 3/14

Home Medications (Include prescription, non- prescription, herbal and vitamin supplements)					
Medication Name	Dose	Route	Frequency		
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?NoYes Da Have you had a pneumococcal vaccine within the last 5 years? Year of last tetanus vaccine: Year of TB skin to Do you have a history of infectious disease (MRSA, TB, Hepati	es <u>t?</u>		Negative		
Do you have an Advance Directive?NoYesLiving WillMedical durable power of attorneyOther Does the hospital have a copy?NoYes	r				
Do you have thoughts of harming yourself or othersNoYes Do you have a history of substance abuse (drugs/Alcohol).No Do you live in a safe environment?	Yes Date	of last us <u>e?</u>			
Form Completed by:		Da	ate:		
Reviewed by:	_ RN Date <u>:</u>	Tii	me:		

PATIENT ID