CHESAPEAKE REGIONAL MEDICAL CENTER

Please answer the following questions to the best of your ability:

Emergency Contact _____ Relationship_____ Phone Number_____

Primary Care Physician_____ Phone number_____

Cardiologist_____ Phone number_____

Allergies: **Latex:** ☐ No ☐ Yes **Iodine/Contrast Dye:** ☐ No ☐ Yes

Other Allergies: Include allergies to drugs, food, iodine, shellfish, and/or other substances

Medication	Type of Reaction	Food/Substance	Type of Reaction

Vaccinations: Flu ☐ No ☐ Yes, Year_____ Pneumonia ☐ No ☐ Yes, Year_____

Height _____ **Weight**_____

☐ Dentures Upper/Lower ☐ Caps/Crowns/Bridges ☐ Loose or chipped teeth
☐ Glasses/Contacts ☐ Cane/Walker

Primary Language: _____

How can we teach you best?
☐ Personal instruction ☐ Reading Material/Pictures ☐ Demonstration ☐ Combination of all

Exercise: Do you exercise? ☐ No ☐ Yes
Can you go up two flights of stairs without chest pain or shortness of breath? ☐ No ☐ Yes

Social History: Tobacco: ☐ Never used ☐ Use tobacco products ☐ Quit Quit Date_____
# of Packs per day_____ # of Years _____ ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew
Alcohol: ☐ No ☐ Yes (please circle) Beer / Liquor / Wine # of Drinks per week _____
Recreational Drugs: ☐ No ☐ Yes How often?_____

Body Piercing: ☐ No ☐ Yes Location_____ Tattoos: ☐ No Yes Location_____

Recent Pregnancy: ☐ No ☐ Yes Could you be pregnant? ☐ No ☐ Yes

Last Menstrual Period:_____ **Breast feeding:** ☐ No ☐ Yes

Do you have an Advance Directive ☐ No ☐ Yes
☐ Living Will ☐ Durable Power of Attorney for Health Care ☐ Organ/Body Donor

Do you have any religious or cultural beliefs/needs that might alter your health care? ☐ No ☐ Yes
Please explain: _____

List any special considerations that you would like us to know: (example: hard of hearing, deaf, blind, cannot read and or speak English, use a walker or cane, on oxygen, etc.) _____

_____

_____ _____

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PLEASE PRINT

Today's Date_____

Name_____ Date of Birth _____

Surgeon's Name_____ Date of Surgery_____

Please indicate with check mark any known conditions that you have and add any which are not listed below.

Anesthesia History: ☐ NONE
- ☐ Family history anesthesia reaction
- ☐ Reaction to Anesthesia
- ☐ Loose Teeth
- ☐ Malignant Hyperthermia
- ☐ Difficult Intubation
- ☐ Nausea/Vomiting
- ☐ Other_____

Airway and Neck: ☐ NONE
- ☐ Difficulty Swallowing
- ☐ Sleep Apnea (If so, device and Setting)_____
- ☐ Other _____

Neuro/Psych (head, brain, spine): ☐ NONE
- ☐ Headaches
- ☐ Parkinson's
- ☐ Spinal Cord Injury
- ☐ Head trauma/injury
- ☐ Seizures
- ☐ Stroke
- ☐ Depression/Anxiety
- ☐ Mental disability
- ☐ Other_____

Cardiovascular (Heart/Circulation): ☐ NONE
- ☐ High Blood Pressure
- ☐ Heart disease
- ☐ Irregular Heart Beat
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Heart Failure
- ☐ Blood clot in legs
- ☐ Mitral Valve Prolapse
- ☐ Heart Stents
- ☐ Peripheral Vascular Disease
- ☐ Other _____
- ☐ Pacemaker (insertion date, make and model (or copy of the card)_____

Pulmonary (lungs): ☐ NONE
- ☐ Asthma
- ☐ Emphysema
- ☐ Lung Cancer
- ☐ Shortness of Breath
- ☐ Blood clot in lungs
- ☐ Other _____

GI/Endocrine: ☐ NONE
- ☐ Diabetes (☐ Controlled with Insulin; ☐ Controlled with pills; ☐ controlled with both insulin & pills)
- ☐ Hiatal Hernia
- ☐ Thyroid disease
- ☐ Hepatitis
- ☐ Reflux/Heartburn
- ☐ Liver Disease
- ☐ Other _____

Musculoskeletal: (muscles/bones): ☐ NONE
- ☐ Arthritis
- ☐ Muscle Weakness
- ☐ Other _____

Renal/GU (kidney, bladder, urinary tract, genitals): ☐ NONE
- ☐ Difficulty Urinating
- ☐ Frequent infections
- ☐ Renal Failure
- ☐ Other _____

Hematological/Cancer (blood issues, cancer): ☐ NONE
- ☐ Anemia
- ☐ Excessive Bleeding
- ☐ Cancer
- ☐ MRSA
- ☐ HIV/AIDS
- Sickle Cell
- ☐ Prior Transfusions
- ☐ Other _____

Surgical History: ☐ NONE
- ☐ Heart Bypass
- ☐ Heart Stent
- ☐ Amputation
- ☐ Lung Surgery
- ☐ Back Surgery
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Kidney
- ☐ Other _____

List other surgeries (can list more on the back of the med list if needed) _____

_____

_____