COMFORT SURGERY CENTER OF SAN ANTONIO

PAST MEDICAL HISTORY QUESTIONNAIRE

Driver: _____ **Relation** _____ **Driver Phone Number** _____

Patient Information:

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

MEDICATION RECONCILIATION

Source of medication list:
□ Patient
□ Family Member / Guardian / Caregiver

DO NOT USE ABBREVIATIONS:
U, IU, QD, QOD, trailing zero (1.0), lack of leading zero (.1), MS, MSO4, ug, AS, AD, AU, OS, OD, PRN, TID, BID,QID

ALLERGIES (Medication & Food)	REACTION	ALLERGIES (Medication & Food)	REACTION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

NO KNOWN ALLERGIES – NKA (Medication, Food)

Medication List: Prescribed OTC, Herbals, Vitamins & Supplements	Dose (Strength)	How Taken?	Frequency (How Often)	Last Day Taken?	PHYSICIAN to indicate: CONTINUE YES	HOLD	NO
1)		Oral/inhaler/drops/topical/injection					
2)		Oral/inhaler/drops/topical/injection					
3)		Oral/inhaler/drops/topical/injection					
4)		Oral/inhaler/drops/topical/injection					
5)		Oral/inhaler/drops/topical/injection					
6)		Oral/inhaler/drops/topical/injection					
7)		Oral/inhaler/drops/topical/injection					
8)		Oral/inhaler/drops/topical/injection					
9)		Oral/inhaler/drops/topical/injection					
10)		Oral/inhaler/drops/topical/injection					
11)		Oral/inhaler/drops/topical/injection					
12)		Oral/inhaler/drops/topical/injection					
13)		Oral/inhaler/drops/topical/injection					
14)		Oral/inhaler/drops/topical/injection					
15)		Oral/inhaler/drops/topical/injection					
16)		Oral/inhaler/drops/topical/injection					
17)		Oral/inhaler/drops/topical/injection					
NEW MEDICATIONS FOLLOWING THIS VISIT:							
1)		Oral/inhaler/drops/topical/injection					
2)		Oral/inhaler/drops/topical/injection					

Medication History Verified by RN:_____ Date:_____ Time_____

(Please Complete Back of Page)

Completed by: Reviewed by:

_____ _____ _____ _____
Patient signature Date Physician signature Date

Please list all previous surgeries/or medical history not listed:

Date/Year	Medical Condition/Surgery/Implants	Date/Year	Medical Condition/Surgery/Implants

Please check whether you have any of these conditions:

	Yes	No	Condition	Yes	No	Condition	Yes	No
Irregular Heartbeat/ Arrhythmias			Diabetes			Problems w/Anesthesia? If Yes: _____		
Coronary Artery Disease			Hyperthyroidism			Family history w/anesthesia (Malignant Hyperthermia)		
Chest Pain/Angina			Hypothyroidism			Lupus		
High blood pressure			Other Thyroid prob			TIA		
Low blood pressure			GERD (Acid Reflux)			Stroke		
Heart Attack			Ulcers			Seizures		
Heart murmur			Hiatal hernia			Parkinson's Disease		
Heart catheterization			Gastrointestinal Bleeding			Peripheral Neuropathy		
Valve replacement			IBS			Multiple Sclerosis		
Stents			Crohns Disease			Frequent Headaches		
Peripheral Vascular Disease			Diverticulitis			Migraines		
Pacemaker/Defibrillator			Other GI problems			Other neuro problems		
Other Heart problems			Anxiety			TB		
High Cholesterol			Depression			HIV or AIDS		
COPD			Bipolar			Hepatitis Type:		
Asthma			Psychiatric Disorders			Other infectious prob		
Allergies			PTSD			MRSA/Staph infection		
Chronic Cough			Excessive bleeding			Dialysis		
Sleep Apnea			Anemia			Kidney Stones		
Shortness of breath			HX-Blood Clots			Chronic Kidney Disease		
Chronic Bronchitis			Other bleeding disorders			Urinary Incontinence		
Chronic Pneumonia			Gout			Cirrhosis		
Emphysema			Arthritis			Special needs: wheelchair, cane, etc.…		
			Fibromyalgia					
Other respiratory problems			Osteoporosis			Glaucoma/Cataracts		
			CANCER Type: _____			Other Diagnosed Conditions		
Circle: Tobacco Products Current or Former Smoker ____ packs/cigarettes per day/week x____years			Recreational drug use Type: _____			Alcohol use Drinks per day/week ____		