The Corvallis Clinic™ Surgery Center

PATIENT HEALTH HISTORY

Patient Name _____Dr._____
(who you're seeing today)

Please answer Yes or No to the following:

Have you had:	Yes	No
Heart Attack	❑	❑
Chest Pain	❑	❑
Murmur	❑	❑
Congestive Heart Failure	❑	❑
Heart Surgery If yes, when? _____	❑	❑
Do you use Nitroglycerin?	❑	❑
If yes, how frequently? _____		
Arrythmia – Fast or irregular	❑	❑
High Blood Pressure	❑	❑
Pacemaker or Implanted Defibrillator	❑	❑
Current problems with:		
• Asthma	❑	❑
• Bronchitis	❑	❑
• Sleep Apnea ____CPAP _____BiPAP	❑	❑
Recent respiratory infection	❑	❑
Chronic or current cough	❑	❑
Shortness of breath	❑	❑
___ at rest ___ with activity		
Can you climb one flight of stairs?	❑	❑
Do you use oxygen at home?	❑	❑
___ all the time ___ only at night		
Lung surgery? When _____ Why _____	❑	❑
Cancer? When _____	❑	❑
Diabetes	❑	❑
Controlled by____Diet _____Oral Agent ____Insulin		

	Yes	No
Do you have Glaucoma?	❑	❑
Do you have a Hiatal Hernia?	❑	❑
Have you had:		
Seizures? Last episode _____	❑	❑
Parkinsons Disease	❑	❑
Neuro-muscular problems	❑	❑
___Paralysis ___Numbness ___Weakness		
Where_____		
Hard of hearing	❑	❑
Deaf	❑	❑
Hearing Aids ___Left ___Right	❑	❑
Anxiety	❑	❑
Panic Attacks	❑	❑
Claustrophobia	❑	❑
Do you:		
Take blood thinners or Aspirin?	❑	❑
Bleed easily?	❑	❑
Use alcohol? If yes, amount_____	❑	❑
Smoke? If yes, amount_____	❑	❑
Use recreational marijuana?	❑	❑
Last Menstrual Period _____		
Height _____ Weight _____		
Who is your primary doctor?_____		
History of MRSA	❑	❑
Have you been seen by a Healthcare Provider in the last 30 days?	❑	❑

Allergies and Reactions (Including medicine / anesthesia / latex / Iodine)_____
_____

Current Medications Including "over the counter drugs" and herbal supplements:_____
_____
_____

Prior Surgeries:_____
_____

Any other diseases, conditions or major medical problems we should know about?_____
_____

Patient Signature: _____ Date:_____

Reviewed by:_____ Date/Time:_____