

SURGERY CLINICS HEALTH ASSESSMENT QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

Weight: _____ Height: _____ Gender: _____ Are you Pregnant?: Yes No

Primary Care Provider Name and Number: _____

In the past year, how many times have you been admitted to a hospital? _____

Yes	No	<u>Past Operations</u>	<u>List type of surgery and date:</u>
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had surgery?	
<input type="checkbox"/>	<input type="checkbox"/>	Any complications with prior surgery?	
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had anesthesia problems?	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of significant problems with anesthesia?	

Medication Allergies:

MEDICAL HISTORY – Please mark (x) in appropriate checkbox below (Yes = Past and Present)

Yes	No	<u>Cardiovascular</u>	Yes	No	<u>Cardiovascular</u>
<input type="checkbox"/>	<input type="checkbox"/>	History of heart disease/heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Heart failure
<input type="checkbox"/>	<input type="checkbox"/>	Atrial fibrillation/Heart racing/irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure/ hypertension
<input type="checkbox"/>	<input type="checkbox"/>	Have a heart or blood vessel stent	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur/ heart valves problems or surgery
<input type="checkbox"/>	<input type="checkbox"/>	Have a pacemaker or defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Leg pain when walking
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain: <input type="checkbox"/> When walking <input type="checkbox"/> At rest <input type="checkbox"/> Now <input type="checkbox"/> Recently	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in legs/feet <input type="checkbox"/> Now <input type="checkbox"/> Recently
Yes	No	<u>Respiratory</u>	Yes	No	<u>Respiratory</u>
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea <input type="checkbox"/> Using CPAP/BiPAP	<input type="checkbox"/>	<input type="checkbox"/>	Use oxygen
<input type="checkbox"/>	<input type="checkbox"/>	Recent Bronchitis/Pneumonia/Virus/Cold	<input type="checkbox"/>	<input type="checkbox"/>	Daily cough/coughing blood/chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/COPD/Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Trouble breathing: <input type="checkbox"/> During activity <input type="checkbox"/> At rest <input type="checkbox"/> Now <input type="checkbox"/> Recently	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
Yes	No	<u>Head/Eyes/Ears/Nose/Throat</u>	Yes	No	<u>Gastrointestinal/Stomach</u>
<input type="checkbox"/>	<input type="checkbox"/>	Persistent hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease/ Hepatitis/ Jaundice/ Yellow
<input type="checkbox"/>	<input type="checkbox"/>	Loose/missing/removable teeth	<input type="checkbox"/>	<input type="checkbox"/>	Black stool or blood in stool
<input type="checkbox"/>	<input type="checkbox"/>	Mouth/jaw/trouble	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Visually impaired or recent vision changes	<input type="checkbox"/>	<input type="checkbox"/>	Acid reflux/Heart burn
<input type="checkbox"/>	<input type="checkbox"/>	Ear or hearing trouble	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcer
Yes	No	<u>Endocrine</u>	Yes	No	<u>Renal</u>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Issues: <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis
Yes	No	<u>Hematology</u>	Yes	No	<u>Prostate Problems</u>
<input type="checkbox"/>	<input type="checkbox"/>	History of bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Problems
<input type="checkbox"/>	<input type="checkbox"/>	History of excessive blood clotting / DVT	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose control of urine?

PLACE PATIENT LABEL HERE

UW Medicine
 Harborview Medical Center – Northwest Hospital & Medical Center
 Valley Medical Center – UW Medical Center
 University of Washington Physicians Seattle, Washington

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Yes	No	<u>Other/ General</u>	Yes	No	<u>Other/ General</u>
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (any type)	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained fever/night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	Persistent skin rash/itching/ skin infection or open wounds	<input type="checkbox"/>	<input type="checkbox"/>	Been treated by a psychiatrist or psychologist in the last year?
<input type="checkbox"/>	<input type="checkbox"/>	MRSA Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	History of Stroke or TIA
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	History of Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Can you lay flat and still for 30 minutes (without shortness of breath, coughing or moving)			

Yes	No	<u>Pain</u>	Yes	No	<u>Pain</u>
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain that has been present for 3 months or longer?	<input type="checkbox"/>	<input type="checkbox"/>	Do you use a pain pump or stimulator?

Over the past 2 weeks, have you been bothered by these problems: (Please check)

	Not at all	Several days	More days than not	Nearly every day
Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Yes	No	<u>Well being</u>
<input type="checkbox"/>	<input type="checkbox"/>	Can you walk 4 blocks on flat ground without shortness of breath or chest pain?
<input type="checkbox"/>	<input type="checkbox"/>	Can you walk up 2 flights of stairs?
<input type="checkbox"/>	<input type="checkbox"/>	Do you need help with your self-care at home (ex. Bathing, dressing, cleaning, etc.)?
<input type="checkbox"/>	<input type="checkbox"/>	Do you need help with your daily activities? (ex. Running errands, paying bills, taking medication)?
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise? Number of times per week? _____ Type: _____
How many hours of sleep do you get a night? _____		
<input type="checkbox"/>	<input type="checkbox"/>	Has your weight changed more than 8 pounds in the last 3 months?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a poor appetite? How many meals do you eat per day? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you fallen in the last 3 months?

		<u>Social History</u>
Tobacco use: <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Past, Quit Year _____		Type: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe
If current/past: Number of years _____ Average daily amount _____		<input type="checkbox"/> Cigars <input type="checkbox"/> E-cigs

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you use methadone/ suboxone/ Buprenorphine/ naltrexone?
<input type="checkbox"/>	<input type="checkbox"/>	Any drug use in last 6 months? (not including marijuana) Which drug(s) _____ If yes: any IV use? <input type="checkbox"/> No <input type="checkbox"/> Yes
How often do you drink alcohol?		When you drink how many do you have per day? _____
<input type="checkbox"/> Never <input type="checkbox"/> Less than monthly <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> 2-3 days a week <input type="checkbox"/> >4 days a week		

PATIENT SIGNATURE	PRINT NAME	TIME	DATE
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Medications Currently Taking:

Comments:

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