Mountain Home Surgery Center
360 Highway 5 N
Mountain Home, AR 72653

Phone: 870-580-0944
Fax: 870-580-0537

MEDICAL HISTORY QUESTIONNAIRE

SURGERY PATIENTS: Please bring your completed Medical History Questionnaire on the day of your surgery.

NAME: ______________________________ DATE: __________________
Last **First** **MI**

List Allergies: ______________________________
☐ Check if NO ALLERGIES

Have you or any blood relatives ever had a reaction to a local or general anesthetic? Yes ☐ No ☐

If yes who ____________ what kind of reaction ____________
and when ____________ .

Are you taking any medications? Yes ☐ No ☐ If Yes, list below and include Non-Prescription drugs.

Name of drug	Dosage	Frequency taken	Condition
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Do you take aspirin or any other blood thinners? Yes ☐ No ☐
If yes, please list names of blood thinners taken: ____________
How often: ____________

PAST MEDICAL HISTORY

List any operations, major illnesses, or injuries you have had including the date.

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________

Have you had any operations or hospitalizations within the last four (4) months? Yes ☐ No ☐

If yes, please indicate the reason ____________

REVIEW OF SYSTEMS

Do you have any problems in the following areas? If yes, check the box to the left.

HEART DISEASE:
- ☐ Heart failure / CHF
- ☐ Heart valve replacement
- ☐ Mitral valve prolapse
- ☐ Irregular heart rate
- ☐ Rheumatic fever
- ☐ Pacemaker / rate
- ☐ Heart attack – Date: __________
- ☐ Other: _____________________

RESPIRATORY / Breathing problems
- ☐ Asthma (childhood / adult)
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Chronic cough
- ☐ COPD (chronic obstructive pulmonary disease)

BLOOD DISEASE
- ☐ Jaundice
- ☐ Hepatitis ___
- ☐ Blood transfusion reactions
- ☐ HIV / AIDS

NEUROLOGICAL:
- ☐ Seizure / convulsions
- ☐ Blackout spells
- ☐ Anxiety / claustrophobia

OTHER:
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Organ transplant
- ☐ Liver disease
- ☐ Cancer
- ☐ Stroke
- ☐ Joint replacement
- ☐ Stent / prosthesis (metal parts)
- ☐ Autoimmune disease

Do you currently smoke? Yes ☐ No ☐ If yes, how much do you smoke? _____ Pack(s)/Day.

Did you ever smoke? Yes ☐ No ☐ If yes, how many years ago ___ ? _____ Pack(s)/Day.

Do you drink alcohol? Yes ☐ No ☐ How often ______________________________________

How many drinks per day? ________________________

Patient's Signature: ____ Date: __________________

Below this line to be completed by Mountain Home Surgery Center

Staff Signature: ____ Date: ___________________

Reviewed and Updated: ________________________ Reviewed and Updated: ________________________
Reviewed and Updated: ________________________ Reviewed and Updated: ________________________
Reviewed and Updated: ________________________ Reviewed and Updated: ________________________