

6. PLEASE GIVE YOUR WEIGHT: _____ YOUR HEIGHT: _____

7. DO YOU CURRENTLY SMOKE CIGARETTES/CIGARS? YES NO IF YES, HOW MANY? _____

7a. DID YOU SMOKE CIGARETTES/CIGARS IN THE PAST? YES NO

8. DO YOU DRINK ALCOHOL DAILY? YES NO IF YES, HOW MUCH? _____

9. LIST ALL PREVIOUS SURGERIES; INCLUDING DATES:

10. HAVE YOU HAD ANY PROBLEMS CONNECTED WITH ANESTHESIA OR OPERATIONS? YES NO
IF YES, PLEASE SPECIFY INCLUDING WHEN, WHERE AND TYPE OF REACTION: _____

11. SOMEONE MUST DRIVE YOU (IF YOU ARE BEING MEDICATED) AND REMAIN AT WESTFALL SURGERY CENTER DURING THE PROCEDURE. WHO WILL BE PROVIDING TRANSPORTATION AND STAYING AT THE CENTER WITH YOU ON THE DAY OF YOUR SURGERY? _____

(PLEASE BE AWARE OF OUR CURRENT LOCATION AT 1065 SENATOR KEATING BLVD.)

SOMEONE MUST BE AT HOME TO HELP YOU WITH YOUR CARE AFTER YOUR PROCEDURE.

12. DO YOU HAVE SOMEONE TO STAY WITH YOU? YES NO

13. DO YOU HAVE ANY CONCERNS OR SPECIAL PROBLEMS THAT WE SHOULD BE AWARE OF? YES NO
IF YES, PLEASE EXPLAIN: _____

14. DO YOU HAVE AN ADVANCE DIRECTIVE, THAT IS, A HEALTH CARE PROXY OR A LIVING WILL? YES NO
IF YES, WHICH? _____

(Please bring with you on the day of your procedure)

WESTFALL SURGERY CENTER HAS PACKETS OF INFORMATION ON ADVANCE DIRECTIVES READILY AVAILABLE FOR ALL PATIENTS.

DATE	SIGNATURE OF PATIENT OR RESPONSIBLE ADULT

FOR FEMALES ONLY

ARE YOU PREGNANT OR SUSPECT THAT YOU MIGHT BE? YES NO
IF YES, DATE OF YOUR LAST MENSTRUAL PERIOD: _____

DO NOT WRITE BELOW THIS LINE

PATIENT HISTORY FORM
REVIEWED BY _____ RN DATE _____

COMMENTS: (If Appropriate) _____

DATE

SIGNATURE