HEALTH CENTRAL HOSPITAL
ORLANDO HEALTH
Surgery Center

ANESTHESIA HISTORY

Have you or a blood relative had a reaction to general or local anesthesia?

☐ Yes ☐ No If yes, please explain: ____________________

ALLERGIES: Medication / Food / Other

☐ None Known ☐ **LATEX**

Reaction:

Reaction:

HEALTH HISTORY

Height: ________ Weight: ________ Last Menstrual Period: ________

	Yes	No		Yes	No
Anemia	☐	☐	Hepatitis - Type: ____________	☐	☐
Asthma	☐	☐			
Arthritis Pain	☐	☐	Hypertension	☐	☐
Bladder Infection	☐	☐	Immunodeficiency Disease	☐	☐
Bleeding Problems	☐	☐	Kidney Disease	☐	☐
Cancer	☐	☐	Kidney Stones	☐	☐
Chest Pain / Angina	☐	☐	Liver Problems	☐	☐
Cholesterol	☐	☐	Migraines	☐	☐
Clotting Abnormalities	☐	☐	Multiple Sclerosis	☐	☐
COPD	☐	☐	Muscular Dystrophy	☐	☐
Depression / Anxiety	☐	☐	Seizures	☐	☐
Diabetes	☐	☐	Sickle Cell	☐	☐
Difficulty with:			Sleep Apnea	☐	☐
			CPAP / BiPAP		
			Wear O_2 at ____		
Hearing	☐	☐	Stomach Problems	☐	☐
Vision	☐	☐	Stroke	☐	☐
Fainting	☐	☐	Thyroid Disease	☐	☐
Fibromyalgia	☐	☐	Tremors/Parkinsons	☐	☐
Heartburn / Acid Reflux / GERD	☐	☐	Tuberculosis	☐	☐
Heart Disease			**Tubes / Drains / Catheters**		
			Colostomy	☐	☐
CHF	☐	☐	Foley	☐	☐
CAD	☐	☐	JP Drain	☐	☐
			Nephrostomy	☐	☐
Heart attack	☐	☐	PICC Line	☐	☐
Other: __________	☐	☐	Portacath	☐	☐

SPECIAL NEEDS

Dentures: ☐ Y ☐ N Loose Teeth: ☐ Y ☐ N

Glasses: ☐ Y ☐ N Contacts: ☐ Y ☐ N Hearing Aids: ☐ Y ☐ N

RELIGIOUS / CULTURAL NEEDS

1.) Do you have any religious or cultural needs we should be aware of? ☐ Yes ☐ No

PSYCHOSOCIAL HISTORY

Interpreter Needed? ☐ Y ☐ N Primary Language Spoken: ________

Alcohol Use ☐ Y ☐ N Amount __________

Current Tobacco Use / Former / None Amount _______ Type ______

Recreational Drug Use ☐ Y ☐ N

DOMESTIC VIOLENCE HIGH RISK SCREENING

1.) Is there any reason to be concerned for your safety? ☐ Yes ☐ No

2.) Do you have any thoughts of hurting yourself or others? ☐ Yes ☐ No

RELATIVE/RIDE INFORMATION

Name and phone number of person 18 years old or older who will be taking you home from surgery / hospital?

Name: ____________________ Phone: ____________________

FOLLOW UP CALL INFORMATION:
What number can you be reached at the day after you return home?

MEDICATIONS: *(IF YOU HAVE A LIST, YOU MAY PROVIDE A COPY INSTEAD OF COMPLETING THIS SECTION)*

1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

SURGICAL HISTORY: *(IF YOU HAVE A LIST, YOU MAY PROVIDE A COPY NSTEAD OF COMPLETING THIS SECTION)*

- ☐ NO PRIOR SURGERY
- ☐ ANGIOPLASTY
- ☐ APPENDECTOMY (APPENDIX REMOVED)
- ☐ ARTHROSCOPY (KNEE / SHOULDER) (RIGHT / LEFT) (SCOPE)
- ☐ BARIATRIC (BYPASS / SLEEVE)
- ☐ BREAST SURGERY
- ☐ CARDIAC BYPASS / CABG
- ☐ CATARACTS
- ☐ COLONOSCOPY / EGD
- ☐ CYST REMOVAL / SKIN CANCER REMOVAL
- ☐ D AND C / ABLATION (DECREASE VAGINAL BLEEDING)
- ☐ GALLBLADDER
- ☐ HEART CATHETERIZATION / STENT
- ☐ HEART VALVE REPLACEMENT
- ☐ HERNIA (INGUINAL / HIATAL / VENTRAL) (RIGHT / LEFT)
- ☐ HYSTERECTOMY
- ☐ IMPLANTED DEFIBRILLATOR
- ☐ KIDNEY REMOVED / STONE REMOVED / STENT (RIGHT / LEFT)
- ☐ MASTECTOMY (RIGHT / LEFT) WITH LYMPH NODES (YES / NO)
- ☐ PACEMAKER
- ☐ PROSTATE PROCEDURE (REMOVAL / BIOPSY)
- ☐ SPINE (BACK / NECK)
- ☐ THYROIDECTOMY (THYROID REMOVED)
- ☐ TONSILS AND ADENOIDS
- ☐ TOTAL KNEE (RIGHT / LEFT)
- ☐ TOTAL HIP (RIGHT / LEFT)
- ☐ TUBAL LIGATION / VASECTOMY (STERILIZATION)
- ☐ OTHER:

AMBULATORY SURGERY CENTER
PROCEDURE ADMISSION HISTORY

Page 1 of 2