HEALTH HISTORY QUESTIONNAIRE

Name: ______________________________ **M / F** Age:__________ Wt:______ Ht:________

Do you wear? *(Circle one)*
Contacts: Y N **Dentures:** Y N **Hearing Aids**: Y N Left / Right / Both
Allergies to Medications: ____
(Please list)
Allergies to Foods, Tape, Soap, LATEX, (list type and reaction)______________________________
____

Who will take you home?___________________Relationship:______________Phone#____________

Current Medications (Prescription/Over-the-Counter/Herbal)– *(please attach list if necessary)*

Medication	Dose/Mg	X per day	Medication	Dose/Mg	X per day
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Have you or a blood relative ever had a complication with anesthesia? ☐ Yes ☐ No
If yes, describe____

Previous Surgeries/dates ____

Medical History *(Check all that apply to you)*

Cardiac	**Lungs**	**Thyroid**
☐ Angina/Chest Pain ☐ Congestive Heart Failure ☐ Irreg. Heart Beats ☐ Coronary Bypass #______ ☐ High Blood Pressure ☐ Pacemaker/ Defibrillator ☐ None	☐ Asthma/Use Inhalers ☐ Emphysema ☐ COPD/Use Oxygen at home? ☐ Bronchitis ☐ Allergies ☐ Sleep Apnea/Wear CPAP? ☐ Smoker, # Packs per Day ☐ None	☐ Hyperthyroid ☐ Hypothyroid ☐ None **Eyes** ☐ Glaucoma ☐ Cataract surgery ☐ Retina surgery ☐ None
Kidney ☐ Chronic Urinary Tract Inf. ☐ Dialysis, When___________ ☐ Voiding at Night #_________ ☐ None	**Liver** ☐ Hepatitis A,B,or C ☐ Cirrhosis ☐ None	**Diabetics** ☐ Oral Meds ☐ Insulin Reg/NPH ☐ Diet Controlled ☐ None
Central Nervous System ☐ Stroke/TIA's ☐ Seizures/Migraines ☐ None **Pregnancy Screen** ☐ Possibility that you might be pregnant? If yes, please speak with your surgeon ☐ N/A	**Other** ☐ Alcohol Use How Often__________ ☐ Drug Use Specify___________ ☐ Bleeding Disorders ☐ History of Mental Illness ☐ **Take/Have taken FLOMAX** ☐ None	**PATIENT STICKER** Pt. Name: Med Record #: Birthdate: Age Surgeon: Surgery Date:

Patient/Guardian Signature:_____________________________ **Date:** ____________ **Time:** __________

Pre-op Nurse Confirms: No changes to the above:_________________ **Date:** __________ **Time:** _________
Pre-op Nurse Signature

Hugo Higa, M.D., LLC • 1600 Kapiolani Blvd #105, Honolulu HI 96814 •808 947-2020 Fax 844 947-2088