Salem Laser and Surgery Center
1330 Commercial SE
Salem, Oregon 97302

PATIENT HEALTH HISTORY

Patient Name____**Dr.**________________________

Have you had: (Check all that apply)

Heart Attack [ ] Chest Pain [ ] Murmur [ ]
Congestive Heart Failure [ ]
Coronary Artery Disease [ ]

	Yes	No
Heart Surgery? If yes, when? __________	[ ]	[ ]
Heart Valve Disease or Rheumatic Fever?	[ ]	[ ]
Do you use Nitroglycerin?	[ ]	[ ]
If yes, how frequent? ___________	[ ]	[ ]
Irregular or Fast Heartbeat	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Pacemaker or Implanted Defibrillator	[ ]	[ ]
___Asthma ___Emphysema ___Bronchitis	[ ]	[ ]
TB If yes, when: _______________		
Do you use inhalers?	[ ]	[ ]
Recent respiratory infection	[ ]	[ ]
Chronic or current cough	[ ]	[ ]
Short of breath: ___At rest ___With activity	[ ]	[ ]
Do you use oxygen at home?	[ ]	[ ]
___All the time ___Only at night		
Lung surgery: When?_________Why? ______________		
Cancer	[ ]	[ ]
Type/Location ____________________		
Bleeding Tendency	[ ]	[ ]
Diabetes	[ ]	[ ]
Controlled by ___ Diet ___Oral agent ___Insulin		

Have you had:	Yes	No
Hiatal Hernia	[ ]	[ ]
Seizures	[ ]	[ ]
Last episode:______________________		
Stroke / TIA If yes, when: ___________	[ ]	[ ]
Parkinsons Disease	[ ]	[ ]
Neuro-muscular problem	[ ]	[ ]
___Paralysis ___Numbness ___Weakness		
Where ______________________		
___Hard of hearing ___Deaf	[ ]	[ ]
Hearing aids: ___ Left ___Right	[ ]	[ ]
___Anxiety ___Panic attacks	[ ]	[ ]
___Claustrophobia	[ ]	[ ]
Do You:		
Take blood thinners or Aspirin?	[ ]	[ ]
Use Alcohol If yes, amount ____________	[ ]	[ ]
Smoke: If yes, amount per day __________	[ ]	[ ]
If in past, when did you quit____________	[ ]	[ ]

How much do you Weigh? ______ Height? _________
Who is your primary doctor:
____

	Yes	No
Bad reaction to anesthesia	[ ]	[ ]
____Self ____Relative		

Advance Directive: [ ] Yes [ ] No

Allergies and Reactions: (Including medicine / anesthesia / latex / Iodine)____

Current Medications Including "over the counter drugs" and herbal supplements:________________________________

Prior Surgeries:____

Any other diseases, conditions or major medical problems we should know about? ______________________________

Patient Signature: ____Date:______________________

Reviewed by:____________________________________Date:______________________Time: ______________

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR PRE-OP APPOINTMENT!!

(PATIENT LABEL)