

Outpatient Surgery Center, Inc.

Personal Health History Form

Patient Name: _____ Allergies: _____

Family Physician _____

Childhood Illnesses: (chickenpox, polio, meningitis, etc.)			<input type="checkbox"/> Smoker _____ yrs _____ ppd _____ yrs quit <input type="checkbox"/> Alcohol		
Please check the boxes according to your history	Yes	No	Please check the boxes according to your history	Yes	No
Are you pregnant or Breastfeeding			Bowel/Stomach Problems: Please Describe		
Seizure disorder					
Headaches or Migraines					
Hearing Problems					
COPD			Kidney/Bladder Problems: Please Describe		
Bronchitis					
Asthma					
Tuberculosis					
Eye Infection			CHF Stroke Heart Attack; When _____ High Blood Pressure Do you have a pacemaker Circulation problems (PVD) Cancer: Please Explain (with dates)		
Glaucoma					
Blurred Vision					
Depth Perception Problems					
Difficulty Seeing at Night					
Double Vision					
Blind Areas					
Diabetic retinopathy					
"Floaters" or spots in the eyes					
Color Blindness					
Cataracts			Liver Disease/Hepatitis		
Macular Degeneration			Numbness in the extremities		
Other: Please Describe					

Are you currently under a physician's care for anything? _____
Please Describe: _____

Patient Label

