

The University of Texas  
Southwestern Medical Center

Aston Ambulatory Care Center

Department Of Surgery

Patient Questionnaire:(to be completed by patient, family member,  
or responsible person, Please review and mark any problems you may have now  
or have had in the past.)

**Patient Health History**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> pacemaker            | <input type="checkbox"/> anemia             | <input type="checkbox"/> fainting/blackout | <input type="checkbox"/> thyroid problems    |
| <input type="checkbox"/> high blood pressure  | <input type="checkbox"/> blood transfusion  | <input type="checkbox"/> seizure           | <input type="checkbox"/> steroid use         |
| <input type="checkbox"/> heart disease        | <input type="checkbox"/> breathing problems | <input type="checkbox"/> mental problems   | <input type="checkbox"/> cancer              |
| <input type="checkbox"/> heart attack         | <input type="checkbox"/> chronic cough      | <input type="checkbox"/> migraine headache | <input type="checkbox"/> chemotherapy        |
| <input type="checkbox"/> chest pain           | <input type="checkbox"/> asthma             | <input type="checkbox"/> depression        | <input type="checkbox"/> radiation treatment |
| <input type="checkbox"/> angina               | <input type="checkbox"/> bronchitis         | <input type="checkbox"/> nerve injury      | <input type="checkbox"/> liver problems      |
| <input type="checkbox"/> irregular heartbeats | <input type="checkbox"/> short of breath    | <input type="checkbox"/> paralysis         | <input type="checkbox"/> hepatitis           |
| <input type="checkbox"/> unable to exercise   | <input type="checkbox"/> pneumonia          | <input type="checkbox"/> back injury       | <input type="checkbox"/> jaundice            |
| <input type="checkbox"/> rheumatic fever      | <input type="checkbox"/> sinus disease      | <input type="checkbox"/> neck injury       | <input type="checkbox"/> hiatal hernia       |
| <input type="checkbox"/> leg cramps/pain      | <input type="checkbox"/> recent cold/flu    | <input type="checkbox"/> herniated disc    | <input type="checkbox"/> frequent heartburn  |
| <input type="checkbox"/> bleeding tendency    | <input type="checkbox"/> emphysema          | <input type="checkbox"/> weakness          | <input type="checkbox"/> ulcers              |
| <input type="checkbox"/> hemophilia           | <input type="checkbox"/> tuberculosis       | <input type="checkbox"/> arthritis         | <input type="checkbox"/> kidney problems     |
| <input type="checkbox"/> easy bruising        | <input type="checkbox"/> stroke             | <input type="checkbox"/> diabetes          |  |

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

Tobacco: no/yes

If yes: amount \_\_\_\_\_ packs/day for \_\_\_\_\_ years

Alcohol: no/yes amount \_\_\_\_\_

street/recreational drugs: no/yes Type \_\_\_\_\_

Could you be pregnant? No/yes

Start date of last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_

ever tested positiv for AIDS or HIV? No/yes

Current Medications: \_\_\_\_\_

Drug or Food Allergies: \_\_\_\_\_

List any medical problems not listed above:

List previous surgery:

Problems with anesthesia: no/yes

Family history of problems with anethesia: no/yes

Comments: \_\_\_\_\_

Name,Address and Phone of Medical Doctor:

Date last seen medical doctor: \_\_\_\_/\_\_\_\_/\_\_\_\_

I have fully reviewed the questionnaire and answered all question truthfully and to the best of my knowledge.  
I understand that my answers could affect my health care, or that of the patient for whom I am responsible.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of patient,parent or guardian \_\_\_\_\_