WYATT SURGERY CENTER
PATIENT SELF HISTORY

PLEASE COMPLETE THIS FORM AND RETURN TO WYATT SURGERY CENTER

Height:_____ Weight:_____

YES	NO	
_____	_____	Treated for High blood pressure
_____	_____	Coronary artery disease
_____	_____	Heart Attack
_____	_____	Atrial Fibrillation or irregular heart beat
_____	_____	Heart Surgery
_____	_____	Stents *heart of elsewhere*
_____	_____	Pacemaker or ICD (defibrillator)
_____	_____	COPD or Emphysema
_____	_____	Asthma
_____	_____	Tobacco Packs per day _____ for how many years _____ how many years ago did you quit smoking?_____
_____	_____	Sleep apnea CPAP or BIPAP
_____	_____	Cancer? Where?_____
_____	_____	Stroke or TIA
_____	_____	Seizures
_____	_____	Migraines or Headaches
_____	_____	Tremors
_____	_____	Arthritis
_____	_____	Neck or Back pain
_____	_____	Diabetes – What does your blood sugar usually run? _____
_____	_____	Thyroid Disease
_____	_____	Ulcers, Indigestion, GERD
_____	_____	Hepatitis or liver disease
_____	_____	Kidney disease
_____	_____	Do you drink alcohol
_____	_____	Did you have any problems with anesthesia?_____
_____	_____	Did you have any hospitalizations or procedures in the past year_____
_____	_____	MRSA infection? Where_____ When_____
_____	_____	Current or Recent Infections_____

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Please LIST THE SURGERIES you have had:

_____
_____
_____
_____
_____

MEDICATION ALLERGIES:

_____
_____
_____
_____
_____

PRESCRIPTION MEDICATIONS / OVER THE COUNTER MEDICATIONS:

MEDICATION NAME	DOSAGE	FREQUENCY

_____ _____

Signature Date