8.31.17

Lansing Surgery Center ☐
1707 Lake Lansing Rd
Lansing MI 48912
Phone: 517-708-3340
Fax: 517-708-3402

PATIENT HEALTH HISTORY

To complete this form online please visit our website at www.lansinggenesis.com or mail/fax to us as soon as possible.

☐ **Genesis Surgery Center**
3400 East Jolly Rd
Lansing MI 48910
Phone: 517-708-3240
Fax: 517-272-1575

Name:______________________ Date of Birth: ______________

Phone numbers: Home:______________ Work:______________ Cell:______________

Surgery/Procedure Reason:______________________ Surgeon: ______________

Surgery Date: ______________ Family Doctor: ______________ Phone:______________

Cardiologist: ______________ Phone:______________ Date Last Seen: ______________

List Past Surgeries or Procedures (Use back if required) **Year** **Complications, Explain**

____
____
____
____

ALLERGIES: SEE PATIENT MEDICATION RECONCILIATION FORM

Do you currently or have you ever had:	Yes	No	If yes , explain
HEART			
High Blood Pressure			
High Cholesterol			
Chest Pain / Angina			
Heart Attack Year?			
Cardiac Stents			
Open Heart Surgery / Bypass			
Artificial Heart Valves			
Pacemaker / Defibrillator			
Irregular Heartbeat / Rate			
Rheumatic Fever			
Heart Murmur / Mitral Valve Prolapse			
Congestive Heart Failure			
Peripheral Vascular Disease			
LUNGS			
Recent Cold/Bronchitis/pneumonia			
Chronic Cough			
Asthma			
Emphysema / COPD			
Able to lay flat?			
Shortness of Breath			
Tuberculosis			
Home Oxygen			
Any Other Lung Problems			
ACTIVITY LEVEL			
Do you get short of breath or have chest pain climbing a flight of stairs?			
Do you get short of breath or have chest pain while performing light housework, i.e. cleaning, vacuuming, dusting?			
NEUROMUSCULAR			
Stroke When?			
Seizures / Epilepsy			
Migraines			
Anxiety / Depression			
Muscular Dystrophy			
Fibromyalgia			
Other Neurological Problems			
ANESTHESIA COMPLICATIONS			
Malignant Hyperthermia			
Difficult Intubation			
Difficulty Recovering			
Nausea / Vomiting			
Motion Sickness			

Do you currently or have you ever had:	Yes	No	If yes , explain
OTHER MEDICAL CONDITIONS			
Cancer Where / What type			
Arthritis			
Joint Replacements			
Metal in / on body			
Anemia / Clotting Disorders			
Ever had MRSA / VRE / Shingles?			
ENDOCRINE			
Diabetes			
Thyroid Disease			
Steroid Use			
Hypoglycemia			
GASTROINTESTINAL			
Heartburn / Reflux			
Ulcers / Gastritis			
History of Vomiting Blood			
Swallowing Problems			
Crohn’s / Colitis / IBS			
Chronic Constipation / Diarrhea			
Blood in stool			
KIDNEY, LIVER			
Hepatitis / Jaundice / Cirrhosis			
Kidney Disease / Dialysis			
AIRWAY			
Difficulty Opening Mouth Fully / T.M.J.			
Sleep Apnea / CPAP			
Snoring			
EYE, EAR, NOSE, THROAT			
Chronic Eye Problems / Glaucoma			
Contacts / Glasses			
Hearing Loss / Hearing Aids			
Dentures / Partials			
Bridgework / Caps / Crowns			
Loose Teeth			

SMOKING, ALCOHOL, OTHER

Recreational drug use: ______________

Smoking: Packs per day/# of years: ______________

Drinks per week:______________

Females: Date of last period: ______________

Anything that we can do to make your surgery more comfortable? (Extra pillows, etc.)______________

Any other medical conditions? Please list: ______________

Name of Person driving you home: ______________

(Please note: It is our policy that your driver must remain at the surgery center during your short stay with us. We will not begin your procedure until your driver is present. Thank you for your kind cooperation.)

Patient/Parent/Guardian Signature: ______________

2nd Admission Signature: ______________

Patient Label