SILLECT
CENTER FOR SURGERY
3545 San Dimas St.
Bakersfield, CA 93301
661-323-1947

Health History Questionnaire

Name: ___________________________ **M/F** Age:____ Wt(lbs.):____ Ht(ft/in):_____

Do you wear?
Contacts: Y N **Dentures:** Y N **Hearing Aids**: Y N Left/Right/Both

Allergies to Medications and Reactions: ____
(Please list)
Allergies to Foods, Tape, Soap, LATEX, etc.____
(Please list)
Who will take you home? ________________Relationship:_____________ Phone#___________

Current Medications (Prescription/Over-the-Counter/Herbal)– *(please attach list if necessary)*

Medication	Dose/Mg	X per day	Medication	Dose/Mg	X per day
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Have you or a blood relative ever had a complication with anesthesia? ☐ Yes ☐ No
If yes, describe____

Previous Surgeries/dates ____

Medical History *(Check all that apply to you)*

Cardiac
- ☐ Angina/Chest Pain
- ☐ Congestive Heart Failure
- ☐ Irreg. Heart Beats
- ☐ Coronary Bypass #____
- ☐ High Blood Pressure
- ☐ Pacemaker

Lungs
- ☐ Asthma/Use Inhalers
- ☐ Emphysema
- ☐ COPD/Use Oxygen at home?
- ☐Bronchitis
- ☐ Allergies
- ☐ Sleep Apnea/Wear CPAP?
- ☐ Smoker, # Packs per Day

Thyroid
- ☐ Hyperthyroid
- ☐ Hypothyroid

Eyes
- ☐ Glaucoma ☐ Cataract surgery
- ☐ Retina surgery

Kidney
- ☐ Chronic Urinary Tract Inf.
- ☐ Dialysis, When_________
- ☐ Voiding at Night #______

Liver
- ☐ Hepatitis A,B,or C
- ☐ Cirrhosis

Diabetics
- ☐ Oral Meds
- ☐ Insulin Reg/NPH
- ☐ Diet Controlled

Central Nervous System
- ☐ Stroke/TIA's
- ☐ Seizures/Migraines

Pregnancy Screen
- ☐ Possibility that you might be pregnant? If yes, please speak with your surgeon

Other
- ☐ Alcohol Use
  How Often_________
- ☐ Drug Use
  Specify__________
- ☐ Bleeding Disorders
- ☐ History of Mental Illness
- ☐ **Take/Have taken FLOMAX**

Please list any previous serious illness or current chronic illness:
____
____
____
____
____

Patient/Guardian Signature:____________________________________ **Date:**_____________

For subsequent surgeries, there have been no changes to the above:

_________________________________ ___________
Patient Signature Date

Place Patient Label Here

Patient Notification and Acknowledgement

Notice of Rights
Sillect Surgery Group, LLC has established a Patient's Bill of Rights, which is provided verbally and in writing in a language and manner the patient or patient's representative understands prior to the date of the procedure. Sillect Surgery Group, LLC expects that observance of these rights will contribute to more effective patient care and greater satisfaction for patients, physicians and the facility.

Financial Disclosure
Sillect Surgery Group, LLC is privately owned and has informed the patient prior to the date of the procedure that their physician may have a proprietary interest in this facility. The patient has the right to choose the facility of his/her choice for health related services.

Advance Directives
It is the policy of Sillect Surgery Group, LLC, regardless of any advance directives or instructions from a health care surrogate or power of attorney, that an unexpected medical emergency, which occurs during treatment at this facility, will be aggressively managed with resuscitative or other stabilizing measures followed by emergency transfer to the closest emergency room. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or health care power of attorney. Acknowledgement of this policy does not revoke or invalidate any current health care directive or health care power of attorney.

Please check the appropriate box. Have you executed an advance health care directive, a living will and/or a power of attorney that authorizes someone to make health care decisions for you?

☐ **Yes**, I have an advance health care directive, living will and/or a power of attorney.

☐ I have provided my advance health care directive, living will and/or a power of attorney to SSI.

☐ **No**, I do not have an advance health care directive, living will and/or a power of attorney.

☐ I would like additional information on advance health care directives
(PLEASE ASK RECEPTIONIST FOR PAMPHLET)

By signing this document, I acknowledge that the above information was given to me prior to my day of surgery, and that I have read and understand the information on notice of patient rights, financial disclosure and advance directives. I agree to the policies of Sillect Surgery Group, LLC. If I have indicated I would like additional information, I acknowledge receipt of that information.

____ ____________________
Patient Signature (If patient is unable to sign, please indicate relationship) **Date**

____ ____________________
Witness Signature **Date**

Patient Sticker

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received Sillect Surgery Group, LLC's Privacy Notice.

________________________________ ________________

Patient or Personal Representative Signature **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

____

____

Witness Signature:

Patient Label