



WINCHESTER MEDICAL CENTER OUTPATIENT HISTORY SCREENING FORM

Please complete this form accurately to assist us in providing the best care possible. Place a question mark in any space you are not sure about or do not understand. We will clarify any questions.
UNLESS OTHERWISE INSTRUCTED, BRING THIS FORM WITH YOU.

Your Medical or Referring Physician: _____

Patient: _____ Physician Performing Procedure: _____

Procedure: _____ Date of Procedure: _____

Have you had this procedure or one similar to it before? Yes No If yes, when:

List all surgical procedures you have had and any implanted devices (artificial joints, pacemaker, etc.)

Did you have a problem with anesthesia or sedation? Yes No Comment: _____

Do you have a durable power of attorney or a living will? (If Yes, you **must** provide a copy for this visit). Yes No

Do you have any cultural or religious beliefs or practices you would like the staff to be aware of? Yes No

Is there any language barrier the staff needs to be aware of? Yes No

Do you feel unsafe in your current relationship? Yes No

Do you feel threatened by someone from a previous relationship? Yes No

Are you advised to take antibiotics before dental work? Yes No

Do you take blood thinners, aspirin, or aspirin-containing drugs routinely? Last dose taken..... Yes No

LIST THE MEDICATIONS YOU ARE ALLERGIC TO OR HAVE ADVERSE REACTION TO: _____

DAILY PHYSICIAN PRESCRIBED MEDICATIONS, OVER THE COUNTER MEDICATIONS, & HERBAL PREPARATIONS (Fill in OR Please Provide a List).

| MEDICATION | DOSE | TIMES TAKEN | MEDICATION | DOSE | TIMES TAKEN |
|------------|------|-------------|------------|------|-------------|
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PLEASE CHECK THE BOX IF YOU HAVE ANY OF THE FOLLOWING

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| Lung Problems <input type="checkbox"/> | Blood pressure problems <input type="checkbox"/> | Any infectious diseases: Hepatitis B/C, HIV/AIDS <input type="checkbox"/> |
| Do you smoke? No. of Packs/Day? <input type="checkbox"/> | Jaundice, hepatitis, Liver problems <input type="checkbox"/> | Could you be pregnant? <input type="checkbox"/> |
| Heart problems <input type="checkbox"/> | Diabetes <input type="checkbox"/> | Other Chronic Conditions/Diseases <input type="checkbox"/> |
| Mitral valve prolapse <input type="checkbox"/> | Kidney problems <input type="checkbox"/> | |
| Heart attack(s) <input type="checkbox"/> | Physical disabilities <input type="checkbox"/> | |