Mercer Health

Personal Health Record of:_____
Birth date:_____ Phone Number:_____

This is a record of your medical history and previous surgical procedures. Included is the Universal Medication Form where your medications and allergies are to be listed.
Complete and update each form as changes occur. Bring both with you to all doctor and hospital visits.

Please list PREVIOUS SURGERIES (including dental) and HOSPITALIZATIONS

	Hospital	Year
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

PLACE "X" IN PROPER COLUMN	YES	NO	DON'T KNOW	EXPLAIN
1. Have you ever used or do you use tobacco products?	☐	☐	☐	How many per day?_____ Ex-smoker for _____years
2. Do you drink alcoholic beverages?	☐	☐	☐	How much? How often?
3. Do you have any:				
Loose, chipped or capped teeth?	☐	☐	☐	
Bridgework, braces, dentures?	☐	☐	☐	
Contact lenses or hearing aid?	☐	☐	☐	
4. Have you ever had any problem with anesthesia?	☐	☐	☐	
5. Has any blood relative had any problem with anesthesia?	☐	☐	☐	
6. Have you ever had or do you have any neurological problems?	☐	☐	☐	
Stroke or mini stroke?	☐	☐	☐	
Convulsions/seizures/Epilepsy?	☐	☐	☐	
Head Injury?	☐	☐	☐	
Fainting?	☐	☐	☐	
Headaches?	☐	☐	☐	
Numbness or tingling in arm or legs?	☐	☐	☐	
Other:	☐	☐	☐	
7. Have you ever had or do you have any heart problems?	☐	☐	☐	If you have a pacemaker or defibrillator, please bring your information card with you.
Implanted pacemaker or defibrillator?	☐	☐	☐	
High blood pressure?	☐	☐	☐	
Low blood pressure?	☐	☐	☐	
Rheumatic or scarlet fever?	☐	☐	☐	
Congestive heart failure?	☐	☐	☐	
Heart attack?	☐	☐	☐	
Heart murmur?	☐	☐	☐	
Chest pains? ☐at rest ☐with activity	☐	☐	☐	
Irregular heart beat?	☐	☐	☐	
High cholesterol or triglycerides?	☐	☐	☐	
Other:	☐	☐	☐	
Is there a family history of heart disease?	☐	☐	☐	
Do you have to take antibiotics to protect your heart before surgery or dental procedures?	☐	☐	☐	
When was your last EKG?			☐	
8. Have you ever had or do you have any blood problems?	☐	☐	☐	
Bleeding tendency?	☐	☐	☐	
Anemia?	☐	☐	☐	
Bruise easily?	☐	☐	☐	
Family history of bleeding problems?	☐	☐	☐	
9. Have you ever had or do you have any lung problems?	☐	☐	☐	
Asthma or Hay Fever?	☐	☐	☐	
Wheezing, Bronchitis?	☐	☐	☐	
Pneumonia?	☐	☐	☐	
Shortness of Breath? ☐at rest ☐with activity	☐	☐	☐	
Coughing?	☐	☐	☐	
COPD (chronic obstructive lung disease), emphysema	☐	☐	☐	
Other:	☐	☐	☐	

PLACE "X" IN PROPER COLUMN	YES	NO	DON'T KNOW	EXPLAIN
10. Have you ever had or do you have any digestive tract problems?	☐	☐	☐	
Hiatal Hernia?	☐	☐	☐	
Heartburn or reflux disease?	☐	☐	☐	
Ulcers?	☐	☐	☐	
Jaundice/hepatitis?	☐	☐	☐	
Pancreatitis?	☐	☐	☐	
Diverticular disease?	☐	☐	☐	
Chronic diarrhea?	☐	☐	☐	
Colitis?	☐	☐	☐	
Other:	☐	☐	☐	
11.Have you ever had or do you have any urinary tract problems?	☐	☐	☐	
Urinary tract infections?	☐	☐	☐	
Kidney stones?	☐	☐	☐	
Other:	☐	☐	☐	
MALES only:				
Do you have prostate problems?	☐	☐	☐	
FEMALES only:				
Are you through menopause?	☐	☐	☐	
If not, date of your last menstrual period:				
Could you be pregnant?	☐	☐	☐	
12. Have you ever had or do you have any glandular problems?	☐	☐	☐	
Diabetes?	☐	☐	☐	
Thyroid?	☐	☐	☐	
Other:	☐	☐	☐	
13. Have you ever had or do you have any muscle/bone problems?	☐	☐	☐	
Arthritis?	☐	☐	☐	
Broken bones?	☐	☐	☐	
Trouble opening mouth?	☐	☐	☐	
Limited joint motion?	☐	☐	☐	
Muscle weakness?	☐	☐	☐	
Other:	☐	☐	☐	
14. Have you ever been treated for nervous or emotional problems?	☐	☐	☐	
Depression?	☐	☐	☐	
Suicidal thoughts?	☐	☐	☐	
Other:	☐	☐	☐	
15. Have you ever had cancer?	☐	☐	☐	
16. Complete Advance Directive information on back page	☐	☐	☐	
17. For pediatric patients, please complete section on back page	☐	☐	☐	

PLEASE LIST ANY OTHER HEALTH HISTORY, PROBLEMS OR CONCERNS:

ADVANCE DIRECTIVES

Do you have any of the following:
☐ ***Living Will** ☐ ***Health Care Power of Attorney** ☐ ***Do Not Resuscitate documents** ☐ **None**
***If not on file at the hospital, please bring a copy with you.**

TYPES OF ADVANCE DIRECTIVES

LIVING WILL: This is a document that allows you to establish in advance, the type of medical care you would want to receive if you were to become permanently unconscious, or if you were to become terminally ill and unable to tell your physician or family what kind of life sustaining treatment you want to receive.

HEALTH CARE POWER OF ATTORNEY: This is a document that allows you to name a person to act on your behalf to make health care decisions for you if you become unable to make decisions for yourself.

DO NOT RESUSCITATE LAW: Gives individuals the opportunity to exercise their right to limit care received in emergency situations and at the end of life. The law authorizes a physician to write an order letting health care personnel know that a patient does not wish to be resuscitated in the event of a cardiac arrest (no palpable pulse) or respiratory arrest (no spontaneous respirations or the presence of labored breathing at end of life).

ORGAN AND TISSUE DONATION: This document allows you to donate any and all organs/tissues you wish upon your death.

MENTAL HEALTH ADVANCE DIRECTIVE: This document allows you to establish, in advance, the type of mental health treatment you would want to receive if you were to lose the capacity to consent.

You might have additional questions or concerns specific to your personal situation. It is important that you discuss your concerns with your family, your physician, your healthcare provider or your lawyer.
If you choose, you can fill out the Advance Directives listed. Please let your physician or nurse know you would like to complete these forms and a hospital representative will contact you. There is no charge to complete these forms. We hope this information is useful in helping you make a decision that is comfortable for you and your family.

For **PEDIATRIC** patients only, please complete the following:

PLACE "X" IN PROPER COLUMN	YES	NO	DON'T KNOW	EXPLAIN
1. Are all immunizations up to date?	☐	☐	☐	
2. Was your child premature?	☐	☐	☐	
Was oxygen required?	☐	☐	☐	
3. Did your child have yellow jaundice requiring blood transfusion?	☐	☐	☐	
4. Does your child have any developmental delays or learning disabilities?	☐	☐	☐	
5. Is your child toilet trained?	☐	☐	☐	
6. Have you discussed the surgery with your child?	☐	☐	☐	
7. What was your child's reaction to these discussions?				
8. Does your child have a nickname? ☐NO ☐YES, it is_____				
9. Does your child have any problems that have not been mentioned?				

CLICK HERE TO SUBMIT FORM TO MERCER HEALTH