COPLEY HOSPITAL

HEALTH HISTORY WORKSHEET

Home ( )_____-_____
Work ( )_____-_____
Cell (978) 886-7806

Name: Lauren Soelch
DOB: 8-12-87

Primary Care Provider: Sarah Vredenburgh PA-C
Provider Phone Number: (802) 888 - 5639

Today's Date 3/27/25 Proposed Procedure Cadaver Graft ACL Reconstruction R Leg
Date of Operation 4/11/25 Type of Interview: In Person Telephone BMI _____ Height _____ Weight _____ Kg

Prior Operations	Date	Other Hospitalizations	Date
Cadaver Graft ACL Recon L Leg	8/29/18	Birth of Zachary	6/29/18
		Birth of William	8/15/20

Medications	Dose	Time Taken	Purpose for Taking
Mirena IUD			Contraceptive

Drugs or Substances Causing Allergy or Bad Response	Response Experienced

VITAL SIGNS:
BP_____TEMP _____PULSE_____ RESP _____ O2 Sats _____

	Yes	No	CLARIFICATION
ACTIVITY			
Can you do the following **WITHOUT** getting Short of Breath:			
Climb two flights of stairs -	✓		
Walk a mile -	✓		
Put groceries up into cupboards or do overhead work -	✓		
Vacuum the house -	✓		
BRAIN			
Have you ever had a Seizure, Convulsion, or Epilepsy?		✓	
(if Yes) -> Are you currently being treated for Seizures?		✓	
Have you ever had a Stroke, CVA, or TIA, or Mini-Stroke?		✓	
HEART			
Do you see a heart doctor?		✓	
Have you ever had a Heart Attack or Heart Failure?		✓	
Have you ever had a Heart Operation or Heart Procedure?		✓	
(such as a stent, echo, stress test, pacemaker)			
Do you have a ☐ Heart Valve problem? ☐ Heart Murmur?		✓	
Have you ever had Irregular Heart Beats?		✓	
Do you get Chest Pain coming from your heart?		✓	
Do you have a Family History of Serious Heart Problems?		✓	

PAGE 2 OF 2	Yes	No	CLARIFICATION
LUNGS			
Do you currently Smoke Tobacco?		✓	
(If Yes) - > How much do you Smoke Per Day?			
If you used to Smoke Tobacco - > When did you Quit?		✓	
Do you have Asthma, Emphysema, or COPD?		✓	
Have you ever used an Inhaler?		✓	
In the past 6 months did you have Pneumonia?		✓	
Do you currently have an Upper Respiratory Infection?		✓	
(such as a head cold, sinusitis, or chest cold)			
Have you ever been diagnosed with Sleep Apnea?		✓	
Do you use a CPAP machine at night?		✓	
Have you ever been Hospitalized due to Breathing Problems?		✓	
BLOOD or BLOOD VESSELS			
Has anyone told you have High Blood Pressure?		✓	
(if Yes) - > Are you being treated for High Blood Pressure now?			
Are you being treated for Anemia?		✓	
Do you have a Bleeding Disorder or Problems with Blood Clotting?		✓	
Have you ever had a Blood Clot in your legs or lungs?		✓	
INTESTINAL/URINARY			
Do you get Heartburn or Acid Reflux?		✓	
Have you ever had Stomach or Intestinal Ulcers?		✓	
Do you have a Kidney Disease?		✓	
Do you see a urologist?		✓	
Any problems with insertion of foley?		✓	
Have you ever had a Liver Problem or Hepatitis?		✓	
ENDOCRINE			
Have you ever had High Blood Sugar?		✓	
Do you have Diabetes?		✓	
Do you have Thyroid Problems?		✓	
MUSCLES/SKELETON			
Do you have Chronic Neck or Back Problems?		✓	
Do you have a Chronic Jaw Problem?		✓	
Do you have a Muscle Disorder?		✓	
EMOTIONAL WELL BEING			
Do you experience Anxiety, Depression, or Both?		✓	
Have you ever been treated for a Psychiatric Disorder?		✓	
OTHER			
Have you had a severe reaction to a Medication, Food or Substance?		✓	
Do you have a Medical Condition that we have not asked you about?		✓	
Do you drink more than 1 Alcoholic Drink/day, or more than 7/week?		✓	
Are you Pregnant or are you concerned you might be Pregnant?		✓	
Do you Ingest, Inject or Inhale any illegal Substances daily or weekly?		✓	
Do you have severe or longstanding Rheumatoid Arthritis?		✓	
Have you been, or are you being treated for a Cancer?		✓	
PRIOR ANESTHESIA			
Have you ever been given an anesthetic?	✓		
(if Yes) - Did you have any Complications?		✓	
Has anyone in your family had problems with Anesthesia?		✓	
Any dentures, partial, chipped or loose teeth?		✓	
Other Medical Conditions not addressed above?		✓	

Signature of Patient: [signature] Date: 3/27/25 Time: 10:00AM

Signature of Pre-Op Nurse: _____ Date: ____/____/_____ Time: _____

Form 582 (8/11)