**OAK TREE SURGERY CENTER**
1931 Oak Tree Rd. Edison, NJ 08820
Tel: (732) 603-8603 Fax: (732) 603-8634

# ADULT - PATIENT MEDICAL HISTORY QUESTIONNAIRE

| Name: | Date of Birth: | Age: | Height: | Weight: |
|---|---|---|---|---|
| | | | | |

Allergy / Reactions: *PLEASE LIST ON "ALLERGY / MEDICATION RECONCILIATION FORM"*

Past operations you have had and their dates: 과거에 수술받은 기록 및 날짜 :

Past hospitalizations and diagnosis: 과거 입원 및 진단

1. Do you have a first degree relative (mother/father, brother/sister, child) with colorectal, endometrial, or ovarian cancer before age 50? ☐ YES ☐ NO If YES, describe_____
   직계가족 (어머니/아버지,형제/자매 ,자녀)중 50세이전에 대장,자궁내막 또는 난소암의 병력이 있습니까?
2. Have you had colorectal cancer, endometrial, or ovarian cancer before age 50 or any of these cancers more than once? ☐ YES ☐ NO If YES, describe _____
   50 세 이전에 결장 직장암, 자궁 내막 암, 난소 암을 미롯 다른암의 병력이있습니까 ?
3. Do you have 3 or more relatives with colorectal, endometrial, or ovarian cancer (any combination)? ☐ YES ☐ NO If YES, describe_____
   가족이나 친척중 3명이상 대장, 자궁ㄴ내막, 또는 난소암의 병력이이 있습니까 ?

☐ YES ☐ NO Have you or anyone in your family experienced malignant hyperthermia / complications with anesthesia? If YES, please describe: _____
본인 또는 본인의 가족중 마취로 인한 악성고열/합병증을 경험한적이있습니까 ?

☐ YES ☐ NO Recent cold or flu? If YES, when? _____
최근 감기 또는 독감에 걸리신적있습니까?

☐ YES ☐ NO Do you smoke? ☐ cigarette ☐ cigar If YES, how long? _____ How many packs a day? _____
당신은 담배를 피우십니까 ?

☐ YES ☐ NO Do you vape? If YES, how long? _____ How many times a day? _____
당신은 전자담배 합니까 ?

☐ YES ☐ NO Do you take recreational drugs? – *important as it may impact your anesthesia care*
Please list (e.g. marijuana, cocaine): _____ How often? _____
당신은 기분전환용 약물/마약 을 사용하십니까? (예 :대마초, 코캐인 )

☐ YES ☐ NO Do you drink alcohol? If YES, how often? _____ How much? _____
당신은 음주 를하십니까 ?

☐ YES ☐ NO Do you have loose teeth, caps, partial bridge, or dentures?
당신은 흔들리는 치아, 캡, 의치 또는 틀니가 있습니까 ?

☐ YES ☐ NO Do you have lung disease, asthma, bronchitis, or emphysema?
Last time you were wheezing? _____
당신은 폐질환,천식,기관지염 또는 폐 기종이있습니까 ?

☐ YES ☐ NO Do you have sleep apnea? If YES, do you use a CPAP machine? ☐ YES ☐ NO
당신은 수면 무호호흡증이있습니까?

☐ YES ☐ NO Do you experience shortness of breath upon climbing up a flight of stairs or less?
당신은 계단을 올라갈때 호호흡곤란이 있으십니까 ?

☐ YES ☐ NO Have you had a heart attack? If YES, when? _____
Have you seen your cardiologist in the last 3 months? ☐ YES ☐ NO
당신은 심장마비를 앓았습니까 ? 지난 3달안에 심장심장전문의를 보신적이있으십니까 ?

☐ YES ☐ NO Do you have any cardiac stents? If YES, when?_____ How many? _____
Have you seen your cardiologist in the last 3 months? ☐ YES ☐ NO
당신은 심장 스텐드가 있습니까 ? 지난 3달안에 심장심장전문의를 보신적이있으십니까 ?

☐ YES ☐ NO Do you have congestive heart failure?
If YES, have you seen your cardiologist in the last 3 months? ☐ YES ☐ NO
당신은 울혈 성 심부전이 있습니까? 지난 3달안에 심장심장전문의를 보신적이있으십니까 ?

☐ YES ☐ NO Do you have angina or chest pain? If YES, how often? _____
Have you seen your cardiologist in the last 3 months? ☐ YES ☐ NO
가슴통증이나 협심증이 있으십니까 ? 지난 3달안에 심장심장전문의를 보신적이있으십니까 ?

☐ YES ☐ NO Have you had a past stress test or cardiac catheterization?
If YES, when and what were the results? _____
과거 스트레스 검사 나 심장 도관 술을 받았습니까?

☐ YES ☐ NO Do you have high blood pressure? If YES, are you taking medication? ☐ YES ☐ NO
고혈압이 있스십니까 ?

☐ YES ☐ NO Do you have high cholesterol? If YES, are you taking medication? ☐ YES ☐ NO
높은 콜레스테롤 이있으십니까 ?

☐ YES ☐ NO Have you ever had a stroke? If YES, when? _____
뇌졸중을 앓은 적이 있습니까?

☐ YES ☐ NO Do you have anemia, sickle cell, or other blood diseases?
If YES, describe: _____
빈혈, 겸상 적혈구 또는 기타 혈액 질환이 있습니까?

☐ YES ☐ NO Do you have diabetes? If YES, describe: _____
당뇨가 있으십니까 ?

☐ YES ☐ NO Do you have any thyroid problems? If YES, describe: _____
갑상선 문제가 있습니까?

☐ YES ☐ NO Do you have any liver problems? If YES, describe: _____
간 문제가 있습니까?

☐ YES ☐ NO Do you have epilepsy or seizures? If YES, describe: _____
간질이나 발작이 있습니까?

☐ YES ☐ NO Do you have headaches, migraines, back or neck pain? If YES, describe: _____
_____
두통, 편두통, 허리 또는 목 통증이 있습니까? 그렇다면 설명하십시오.

☐ YES ☐ NO Do you have any weakness or numbness in a limb? If YES, describe: _____
사지에 약점이나 무감각이 있습니까? 그렇다면 설명하십시오.

☐ YES ☐ NO Do you have any excessive bleeding or bruising? (e.g. nosebleed) If YES, describe: _____
_____
과도한 출혈이나 멍이 있습니까? (예 : 코피) 예 인 경우 설명

☐ YES ☐ NO Do you have a hiatal hernia?
열공 탈장이 있습니까?

☐ YES ☐ NO Do you have arthritis or any rheumatological disease?
관절염이나 류마티스 질환이 있습니까?

☐ YES ☐ NO Do you have any other significant illness(es)? If YES, describe: _____
_____
다른 중대한 질병이 있습니까? 그렇다면 설명하십시오.

☐ YES ☐ NO FEMALE PATIENTS: Could you be pregnant?
여성 환자 : 임신 가능성이 있습니까?

☐ YES ☐ NO Has your Medical Doctor (family doctor / primary care doctor) cleared you for your procedure?
Medical Doctor name: _____
귀하의 의사 (가정 의사 / 주치의)가 귀하의 시술을 승인 했습니까? 의사 이름 :

☐ YES ☐ NO If you have heart disease, has your cardiologist cleared you for your procedure?
Cardiologist name: _____
심장 질환이있는 경우, 심장 전문의가 시술을 위해 귀하를 승인 했습니까? 심장 전문의 이름 :

**I understand that I am not to eat, or drink as instructed prior to the day of my procedure unless instructed otherwise by the surgery center staff. I also understand that I must have a responsible adult to accompany me home (NO taxi service will be permitted) after discharge from Oak Tree Surgery Center.**

Oak Tree Surgery Center 직원의 지시가없는 한 시술 전 지시에 금식해야함을 이해합니다.
또한 시술후 수술센타 퇴원시에는 보호자가 동행해야함을 이해합니다 다만 (택시 서비스는 허용되지 않습니다).

_____ _____
Patient Signature Date