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| TODAY'S DATE | | | | | / | / |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PATIENT | | |  |  |  |  |  |  | PREFERRED |  |  |  | PHONE | | | | |  |  |  |  |  |  |  |
| NAME: | | |  |  |  |  |  |  | NAME: |  | # | | |  |  |  |  |  | AGE |  | HT. | WT. | |  |
| FOR | | |  | NONE | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ADMISSION / LIST | | | | | | MEDICATIONS | FOODS |  | LATEX | OTHERS |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | **PREVIOUS HOSPITALIZATOIN(S) OR OPERATIONS** | | | | |  |  |  |  |  | **CURRENT AND RECENT MEDICATIONS** | | | | | |  |  |  |  |  |  |
|  |  |  |  |  |  | (INDICATE APPROXIMATE YEAR) | |  | (INCLUDE PRESCRIPTIONS, EYE DROPS, OVER-THE-COUNTER MEDS, ASPIRIN, IBUPROFEN, DIET AIDES & DOSAGE) | | | | | | | | | | | | | | |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **CHECK IF YOU HAVE A BAD REACTION TO ANESTHESIA?** X YES | | | | | | | |  | X NO |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **HAS A BLOOD RELATIVE HAD A BAD REACTION TO ANESTHESIA?** | | | | | | | | X YES X NO | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **YES** |  | **NO** | **HAVE YOU HAD:** | | | |  |  |  |  |  | **YES** | | **NO** | | **HAVE YOU HAD:** | |  |  |  |  |  |  |  |
|  |  |  | DIABETES | | | |  |  |  |  |  |  |  |  |  | WOMEN: IS THERE A POSSIBILITY YOU ARE PREGNANT? | | | | | | | |  |
|  |  |  | HYPOGLYCEMIA (Low Blood Sugar) | | | |  |  |  |  |  |  |  |  |  | LAST MENSTRUAL PERIOD: | | |  |  |  |  |  |  |
|  |  |  | THYROID PROBLEMS | | | |  |  |  |  |  |  |  |  |  | DO YOU HAVE A HISTORY OF SMOKING? | | | | | |  |  |  |
|  |  |  | HEART PROBLEMS (Rheumatic Fever, Murmur, Chest Pain, Heart Attack, | | | | | | | |  |  |  |  |  | PACKS PER DAY | |  |  |  | DATE QUIT |  |  |  |
|  |  |  | Irregular Heartbeat, EKG changes, Angina, Ankle Swelling, Valve Replacement, etc.) | | | | | | | |  |  |  |  |  | DO YOU DRINK ALCOHOLIC BEVERAGES | | | | | |  |  |  |
|  |  |  | BLOOD CLOTS, TRANSFUSION PROBLEMS, OR BLEEDING | | | | | | |  |  |  |  |  |  | HOW OFTEN: | |  |  |  | HOW MUCH? | |  |  |
|  |  |  | TENDENCY (Hemophilia etc.) | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | HIGH BLOOD PRESSURE | | | |  |  |  |  |  |  |  |  |  | DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE OR ADDICTION? | | | | | | | |  |
|  |  |  | STROKE (Weakness/Numbness on one side, Difficulty Speaking, Loss of Vision etc.) | | | | | | | |  |  |  |  |  | DO YOU HAVE ANY OF THE FOLLOWING: | | | | | |  |  |  |
|  |  |  | SEIZURES (Epilepsy, Convulsions, Blackouts, etc.) | | | | |  |  |  |  |  |  |  |  | False Teeth | | Bridges | |  |  | Braces |  |  |
|  |  |  | NEUROLOGICAL PROBLEMS (Loss of Sensation, Numbness, Tingling, etc) | | | | | | | |  |  |  |  |  | Loose Teeth | | Capped Teeth | | | | Retainers |  |  |
|  |  |  | SEVERE HEADACHES | | | |  |  |  |  |  |  |  |  |  | DO YOU WEAR CONTACT LENSES? | | | | | |  |  |  |
|  |  |  | LUNG PROBLEMS (Asthma, Chronic Cough, Pneumonia, Wheezing, | | | | | | |  |  |  |  |  |  | ARE YOU RECEIVING TREATMENT FOR GLAUCOMA? | | | | | | | |  |
|  |  |  | Shortness of Breath, Emphysema, Abnormal Chest X-ray, etc. | | | | | | |  |  |  |  |  |  | DO YOU HAVE ANY SPECIAL COMMUNICATION NEEDS? Vision \_\_\_\_ | | | | | | | |  |
|  |  |  | TUBERCULOSIS/TB | | | |  |  |  |  |  |  |  |  |  | Hearing \_\_\_\_\_ Language \_\_\_\_\_\_ Speech \_\_\_\_\_ | | | | | | | |  |
|  |  |  | SLEEP APNEA (Breathing Interruption During Sleep, etc.) | | | | | | |  |  |  |  |  |  | DO YOU HAVE ANY PHYSICAL LIMITATIONS? | | | | | |  |  |  |
|  |  |  | LIVER PROBLEMS (Jaundice, Hepatitis, etc.) | | | | |  |  |  |  |  |  |  |  | DO YOU HAVE ANY ENVIRONMENTAL CONCERNS? | | | | | | | |  |
|  |  |  | KIDNEY, BLADDER OR PROSTATE PROBLEMS (Infections, etc.) | | | | | | |  |  |  |  |  |  | (Room Temperature, Lighting, etc.) | | | | | |  |  |  |
|  |  |  | STOMACH PROBLEMS (Ulcer, Hiatal Hernia, Reflux, Heartburn, etc.) | | | | | | |  |  |  |  |  |  | DO YOU HAVE ANY SPECIAL REQUESTS? | | | | | |  |  |  |
|  |  |  | BOWL PROBLEMS (Irritable Bowel, Diverticulosis, etc.) | | | | | | |  |  |  |  |  |  | DO YOU CURRENTLY NEED ASSISTANCE TO GET AROUND THE HOUSE? | | | | | | | |  |
|  |  |  | BACK TROUBLE (Strain, Disc Problems, Numbness/Tingling of Hands or Feet, etc.) | | | | | | | |  |  |  |  |  | DO ERRANDS, AND TAKE CARE OF YOUR PERSONAL NEEDS? | | | | | | | |  |
|  |  |  | BROKEN BONES OF HEAD, NECK OR SPINE OR RESTRICTIONS IN MOVEMENT | | | | | | | |  |  |  |  |  | WOULD YOU LIKE TO DISCUSS ANY CONCERNS OR | | | | | | | |  |
|  |  |  | DIFFICULTY OPENING MOUTH (TMJ, etc.) | | | | |  |  |  |  |  |  |  |  | FEARS REGARDING THIS PROCEDURE? | | | | | |  |  |  |
|  |  |  | ARTHRITIS | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | MUSCLE DISORDERS (MD, Myesthenia Gravis, etc.) | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | CANCER | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | MENTAL HEALTH / PHOBIAS (Anxiety, Depression, Psychosis, etc.) | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | MENTAL DISABILITY (Confusion, Memory Loss, Downs Syndrome, etc.) | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | SKIN PROBLEMS (Eczema, Fragile, etc.) | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | OTHER MEDICAL PROBLEMS / COMMENTS | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | |  | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | ANY ILLNESS, COLD, COUGH OR FEVER WITHIN THE LAST WEEK? | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | RECENT EXPOSURE TO ANY COMMUNICABLE DISEASES? | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | (Chicken Pox, Measles etc.) | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| YES | | NO |  |  |  |  |  |  |  |  | YES | | NO | | | | |  |  |  |  |  |  |  |
|  |  |  |  | 1. | | Do you have a history of falling down? | |  |  |  |  |  |  |  | 9. | | Do you have any problems or complaints regarding | | | | | | |  |
|  |  |  |  | 2. |  | Have you used or do you currently use any of the following services? | | | | |  |  |  |  |  |  | your bowel movements? | | Constipation | | |  |  |  |
|  |  |  |  |  |  | Homemaker services | |  |  |  |  |  |  |  |  |  | Diarrhea | Black / bloody stools | | | | | |  |
|  |  |  |  |  |  | Meals on Wheels | |  |  |  |  |  |  |  |  |  | Other: |  |  |  |  |  |  |  |
|  |  |  |  |  |  | Transportation |  |  |  |  |  |  |  |  | 10. | | Do you use anything to maintain your usual bowel | | | | | | |  |
|  |  |  |  |  |  | Medical supplies / Oxygen | |  |  |  |  |  |  |  |  |  | pattern? Enemas | Laxatives | | | |  |  |  |
|  |  |  |  |  |  | Nursing services |  |  |  |  |  |  |  |  |  |  | Special diet | | Fiber supplements | | | | |  |
|  |  |  |  |  |  | Other: |  |  |  |  |  |  |  |  |  |  | Stool softeners | |  | Other | |  |  |  |
|  |  |  |  | 3. |  | Have you been or are you afraid you will be | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | physically, verbally of mentally abused by someone? | | | |  |  |  |  |  | 11. | | Do you have any problems sleeping? | | | | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | 4. |  | Would you like to discuss any financial concerns regarding: | | | |  |  |  |  |  |  |  | Insomnia | Pain | |  | Breathing difficulties | | |  |
|  |  |  |  |  |  | Cost of this hospitalization | |  |  |  |  |  |  |  |  |  | Up at night to use bathroom | | | | |  |  |  |
|  |  |  |  |  |  | Questions about insurance / Medicare coverage | | | |  |  |  |  |  |  |  | Other: |  |  |  |  |  |  |  |
|  |  |  |  |  |  | Cost of ongoing treatment / medications & supplies | | | | |  |  |  |  | 12. | | Would you like to discuss any concerns about the | | | | | | |  |
|  |  |  |  | 5. |  | In the last 6 months, have you experienced: | | | |  |  |  |  |  |  |  | impact of your condition on your sexuality? | | | | |  |  |  |
|  |  |  |  |  |  | Weight change | Appetite change | | |  |  |  |  |  |  |  | Explain: |  |  |  |  |  |  |  |
|  |  |  |  |  |  | Explain: |  |  |  |  |  |  |  |  | 13. | | Are there any cultural or religious practices which are | | | | | | |  |
|  |  |  |  | 6. |  | Are you on a special diet or is there anything you | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | cannot eat? Explain: |  |  |  |  |  |  |  |  |  |  | important to maintain or perform during this hospitalization? | | | | | | |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | 7. |  | Do you have any difficulty chewing, swallowing or | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | with digestion? Explain: |  |  |  |  |  |  |  |  | 14. | | Is there anything else you want to ask about or tell us | | | | | | |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | 8. |  | Do you have any problems or complaints regarding urination? | | | | |  |  |  |  |  |  | that will help you deal with your condition? | | | | |  |  |  |
|  |  |  |  |  |  | Pain / Burning | Control |  |  |  |  |  |  |  | 15. | | Who will be the key support person for you during this | | | | | | |  |
|  |  |  |  |  |  | Frequency | Other |  |  |  |  |  |  |  |  |  | hospitalization? |  |  |  |  |  |  |  |