|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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) |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **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? |  |  |  |  |  |  |  |