PRE-ADMISSION HISTORY ASSESSMENT

Patient Name: ____ Date of Birth: ______________ Age: __________ Sex: M F
Home Number: ___________________________ Cell Number: ___________________________
Family Doctor: _________________________________ Date last seen: ___________________ Phone Number: ____________________________
Other Doctors/Specialists seen within last year (cardiologist, pulmonologist, etc): ____
Do you have an allergic reaction to <u>medication or food</u>? ☐ Yes ☐ No If Yes, please list the allergies and reactions below: ______________________
____
____

Check if an allergy or reaction to: ☐ **Latex** ☐ Contrast Dye ☐ Adhesive Tape ☐ Iodine ☐ Dairy ☐ Other: ______________________________
Do you have an allergy to: ☐ Bananas ☐ Kiwi ☐ Nuts ☐ Avocado

To your knowledge, do you have now or have you ever had the following:

Current or past history of respiratory breathing problems? ☐ **No** ☐ **Yes**	**If Yes ✓**	**Current or past history of cardiovascular or circulatory problems?** ☐ **No** ☐ **Yes**	**If Yes ✓**	**Current or past history of neurological problems?** ☐ **No** ☐ **Yes**	**If Yes ✓**
Recent cold, Bronchitis or Pneumonia		Irregular Heart Beat ☐ Palpitations ☐		Tremors ☐ Parkinson's ☐	
Asbestosis		Heart Condition- Name:		Stroke ☐ TIA *(Mini-Stroke)* ☐ Year:____	
History of Asthma or Wheezing		Blood Clots Last episode:		Multiple Sclerosis ☐ Polio ☐	
Sleep Apnea/Excessive Snoring		Rheumatic Fever		Weakness or Paralysis	
Use CPAP		High blood pressure:		Head Injury Year: __________	
Persistent productive cough?		Controlled* ☐ Uncontrolled* ☐		Neuropathy	
Cough up blood?		Skipped Heartbeat/Fluttering/Murmur		Epilepsy/Seizures Last: __________	
Shortness of Breath with Exertion at Rest		Heart Attack Year __________		Migraines	
Emphysema / COPD		High Cholesterol		Frequent Blackouts ☐ Vertigo ☐	
Chronic Cough, Bronchitis, Lung Problems		Heart Failure		Restless Leg Syndrome	
Are you on oxygen? LPM: _________		Chest Discomfort ☐ Angina ☐		Brain Tumor- Diagnosed Date: _______	
Abnormal Chest X-Ray Date: ________		Frequency:_______________________		Numbness- Location: ______________	
Previous TB exposure Year:________		Problems with Arteries in neck		**Current or past history of endocrine problems?** ☐ **No** ☐ **Yes**	**If Yes ✓**
Tuberculosis/Year: ___________		Problems with Poor circulation to legs & feet			
Do you see a pulmonologist?		Do you see a cardiologist?		Parathyroid Disorder	
Current or past history of hematologic (bleeding) problems? ☐ **No** ☐ **Yes**	**If Yes ✓**	**Current or past history of gastrointestinal (digestive) problems?** ☐ **No** ☐ **Yes**	**If Yes ✓**	Thyroid Disorder: Hyper ☐ Hypo ☐	
History of Anemia (low blood count)		Frequent Nausea ☐ Frequent Vomiting ☐		Diabetes: Type I ☐ Type II ☐ Controlled* ☐ Uncontrolled* ☐ Treated by: Insulin ☐ Pills ☐ Diet ☐	
Sickle-Cell Anemia ☐ Trait ☐		Liver Disease/Jaundice/Hepatitis		Adrenal Disorder ☐ Pituitary ☐	
History of Bleeding or Bruising		Chronic Heartburn		**Current or past history of urology problems?** ☐ **No** ☐ **Yes**	**If Yes ✓**
Blood Transfusion Year: _____________		Stomach Bleed/Ulcer			
Phlebitis Last episode: ______________		Hiatal Hernia		Kidney Stones	
Current or past history of psychosocial (mental health) problems? ☐ **No** ☐ **Yes**	**If Yes ✓**	Reflux		Enlarged Prostate	
		Crohns		Dialysis: Peritoneal ☐ Hemo ☐	
Anxiety ☐ Depression ☐		Diverticulosis		Incontinence: Urinary ☐ Bowel ☐	
Anorexia ☐ Bulimia ☐		IBS ☐ Ulcerative Colitis ☐		Urinary Tract Infections	
PTSD ☐ Panic Disorder ☐		Gastroparesis		Interstitial Cystitis	
Alzheimer's ☐ Dementia ☐		Pancreatitis		Frequency	
Schizophrenia ☐ Bipolar ☐		Trouble Swallowing		**Current or past hx of developmental problems?** ☐ **No** ☐ **Yes**	**If Yes ✓**
Do you have thoughts about harming yourself or others? *If yes-refer to supervisor*		Gallbladder Problems			
		Motion Sickness		Learning Disabilities	
Current or past history of musculoskeletal problems? ☐ **No** ☐ **Yes**	**If Yes ✓**	**Current or past history of dental implants/problems?** ☐ **No** ☐ **Yes**	**If Yes ✓**	Autism	
				ADHD	
Chronic Neck ☐ Back ☐		Dentures: Full ☐ Partial ☐		**Current or past hx of anesthesia or other problems?** ☐ **No** ☐ **Yes**	**If Yes ✓**
TMJ or Problems opening mouth wide		Caps ☐ Implants ☐ Crowns ☐			
Arthritis: CIA ☐ RA ☐ Gout ☐		Veneers ☐ Bondings ☐		Cancer Where: _______________	
Scoliosis		Braces ☐ Retainer ☐		HIV ☐ AIDs ☐	
Osteoporosis ☐ Osteopenia ☐		Loose teeth- Location: __________________		Anesthesia complications?	
		Chipped teeth- Location: ________________		Post-op nausea ☐ Post-op vomiting ☐	
				High fevers associated with anesthesia?	

*Per patient statement – Controlled = readings are regularly WNL

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Pre-Admission History Assessment

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Patient Name
Date of Birth:
Surgeon:

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Current or past history of ear/eye problems? ☐ No ☐ Yes	If Yes ✓	Current or past history of skin problems? ☐ No ☐ Yes	If Yes ✓	Current or past history of surgical cardiac history? ☐ No ☐ Yes	If Yes ✓
Hearing Impaired		Rashes ☐ Rosaceas ☐		Cardiac Catheter Year: __________	
Deaf		Open Wounds: Location_________________		Stents Number: ______ Year: ______	
Use of Hearing Aids		Eczema ☐ Psoriasis ☐		Pacemaker ☐ AICD ☐ Brand/Model: ______________________	
Glaucoma ☐ Macular Degen ☐		Shingles			
Blindness		MRSA- Location: __________ Date: ______		**Immunization history up-to-date as appropriate? ☐ No ☐ Yes**	**If No ✓**
Visual Impairment		C-Diff- Date: __________________			
Contact Lenses ☐ Glasses ☐		Other infection?		Tetanus shot out of date- Date of last: __________	
Implants ☐ Cataracts ☐		Wounds or non-healing sores- Location: __________________________		Pneumonia vaccine request-Date of last: _________	
				Influenza vaccine request- Date of last:__________	

☐ N/A **Obstetrics & Gynecology**	**Uncertain**	**Yes**	**No**		**Yes**	**No**
Are you pregnant?				Are you breastfeeding?		
Have you recently been pregnant?				Number of pregnancies ______		
Last menstrual period ______________				Number of live births ______		
Menopausal Yes ☐ No ☐				Number of spontaneous or other abortions ___________		

Please list all previous surgeries or procedures requiring anesthesia. Attach additional page if necessary.

Past Surgeries	Yes	Date	Past Surgeries	Yes	Date	Past Surgeries	Yes	Date
Cataract			Gallbladder			Prostate		
Tonsillectomy			Hernia			Joint		
Heart Bypass/Open Heart			Skin Graft			Back		
Heart Valve			Bladder			Neck		
Other Vascular Surgery			D & C			Splenectomy		
Lung			Hysterectomy			Breast		
Appendectomy			Tubal Ligation			C-Section		
Colon/Bowel/Intestines			Kidney			Ear Tubes		
Thyroidectomy			Pain Injection					
Surgeries within the last 30 days:								
Additional Surgeries/Comments (include date):								

Have you had any problems with anesthesia? ☐ No ☐ Yes- If yes, explain: ____

Have any of your blood relatives (Parents, Grandparents, Siblings) had problems with anesthesia? ☐ No ☐ Yes- If yes, explain: ___________________________

Language Used: English **Other Language*:** ____

*Interpreter: Language Link Services *(include first & last name of interpreter)*:____

Do you have religious or moral objections to medically necessary blood transfusions? ☐ No ☐ Yes- If yes, describe: __________________________________

Do you have any other special concerns? ____

Should we be aware of any cultural or religious beliefs that may affect your health care? ☐ No ☐ Yes- If yes, describe:______________________________

How can we meet your spiritual needs while you are with us for your surgery/procedure? ____

Have you traveled outside of the United States within the last 30 days? ☐ No ☐ Yes- If Yes, Have you traveled to ☐ Guinea, ☐ Liberia, ☐ Sierra Leone, ☐ Nigeria, or ☐ Mali. If yes, have you experienced a ☐ Fever, ☐ Headache, and/or ☐ Other symptoms of Ebola Hemorrhagic Fever: ___________________________________

You must have a responsible adult (age 18 or older) driving you home after surgery. Name of individual: ____________________ Contact information: _______________

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ADVANCED HEALTH CARE DIRECTIVE

Do you have an Advanced Directive (Living Will)? ☐ Yes ☐ No
↳ If yes, please provide a copy for your medical records

Do you have a medical power of attorney? ☐ Yes ☐ No
↳ If yes, who/relationship: ______________________________

Would you like additional information on Advance Directives? ☐ Yes ☐ No

Do you have a 'Do Not Resuscitate'? ☐ Yes* ☐ No
↳ *If yes, patient advised life-saving measures will be conducted during the surgical procedure and immediate post-op period

NUTRITIONAL SCREENING

Are you on any special diet? ☐ Yes ☐ No ☐ Renal ☐ Diabetic ☐ Cardiac

Are you a Vegetarian? ☐ Yes ☐ No

Gluten intolerance? ☐ Yes ☐ No

Have you had any unintentional weight loss of more than 10 pounds over the past 3 months? ☐ Yes ☐ No

FALL RISK QUESTIONNAIRE

Have you fallen within the last 30 days? ☐ *Yes ☐ No
Level of vision impairment: ☐ None ☐ Mild ☐ Moderate ☐ *Severe
Do you have a history of becoming confused/disoriented? ☐ *Yes ☐ No

Do you use ambulatory devices (wheelchair, walker, cane)? ☐ *Yes ☐ No
Do you have a history of seizures? ☐ *Yes ☐ No
Do you take medications routinely that make you sleepy (*sedatives*)? ☐ Yes ☐ No

If 2 or more indicators are present or 1 or > *indicator is present, fall risk education provided to patient & nursing staff notified for room placement

SUBSTANCE SCREENING

Do you smoke? ☐ Yes ☐ No

Did you ever smoke? ☐ Yes ☐ No

Cigarettes ☐ Yes ☐ No
Chew tobacco ☐ Yes ☐ No
Pipe ☐ Yes ☐ No
Cigars ☐ Yes ☐ No
Marijuana ☐ Yes ☐ No

If yes, how much per day? ____
Total number of years smoked: _________________Quit Date: ___________

Do you drink alcohol? ☐ Yes ☐ No
If yes, how much (quantify) ____

Recovering alcoholic ☐ Yes ☐ No
If yes, how long ____

Do you use Recreational drugs or IV drugs? ☐ Yes ☐ No
If yes, please explain ____

Do you drink coffee/tea or caffeinated beverages? ☐ Yes ☐ No
If yes, how much (quantify) ______________________________________

RISK ASSESSMENT TOOL FOR DVT OR PE

Please check the following statements that *apply now* or *within the last 30 days:*

☐ Age 40– 60 years ☐ Obesity (BMI > 30) ☐ Minor surgery (less than 60 minutes) is planned ☐ Family History of VTE ☐ Pregnancy or Postpartum < 1 month ☐ Leg swelling, Ulcers, Varicose Veins ☐ Estrogen Therapy/ Birth Control Pills/ HRT ☐ Use of Tobacco (Smoking, chewed tobacco) ☐ Dehydration ☐ Nephrotic Syndrome (>4GM Proteinuria/day) ☐ Acute Infection other than Sepsis ☐ A history of Inflammatory Bowel Disease (IBD) *(for example, Crohn's disease or ulcerative colitis)* ☐ Implanted IV Lines (ex: PICC, Port)	☐ Age 60 or greater ☐ Immobility- Ambulates < 100 feet 3 times a day ☐ Acute Respiratory Failure/Severe COPD ☐ Planned major surgery lasting longer than 60 minutes ☐ Anticipated Bed Confinement/ Immobilization > 24 hours	☐ Malignancy and/or Chemotherapy ☐ Documented History of VTE ☐ Sepsis ☐ Congestive Heart Failure or Myocardial Infarction ☐ Hypercoagulable Syndrome Add 3 points for each of the top statements **Total Score**____________ ☐ Major Trauma or Spinal Cord Injury* ☐ Stroke with Paralysis* ☐ Elective Knee or Hip Arthroplasty* ☐ Hip, Pelvis or Leg Fractured*
Add 1 point for each of the checked statements **Total Score**____________	Add 2 points for each of the checked statements **Total Score**____________	Add 5 points for each of the bottom* statements **Total Score**____________

☐ N/A- To be completed on all patients greater than 16 years of age and scheduled for procedures greater than 45 minutes

Low Risk: 1 point or less *Moderate Risk: 2 points* *High Risk: 3-4 points* *Very High Risk: 5+ points*

Total Score: ________________________________ **Risk Level:** ______________________

If score greater than 3:
☐ Prophylaxis treatment already ordered within pre-operative orders
☐ Physician notified of risk assessment score if greater than 3 Physician Name: _____________________ Date/Time Notified: _________________________

Details of communication to be documented in Nursing Notes

Additional information regarding health history: ____

____

History obtained from: _______________________________________Relationship to Patient: _______________________________Date: _____________________

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