OneCore Health

PATIENT HISTORY QUESTIONNAIRE

Primary Care Doctor: _________________ (Name) _________________ (Phone Number) ☐ N/A **Cardiologist:** _________________ (Name) _________________ (Phone Number) ☐ N/A

Social History: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er)
Language Used: ☐ English ☐ Other _____________
Living Status: ☐ Home w/Family ☐ Home Alone ☐ Assisted Living ☐ Nursing Home

Weight (Pounds) ________ **Height** ______ft ______in

Have you had:

1. Heart disease, stents, bypass, MI, chest pain Irreg. heartbeat, PVD.. Yes ☐ No ☐
2. Abnormal EKG.. Yes ☐ No ☐
3. Congestive Heart Failure .... Yes ☐ No ☐
4. Pacemaker/Implanted Defibrillator............... Yes ☐ No ☐
5. Heart Valve Replacement ....Yes ☐ No ☐
6. High Blood Pressure/Low Blood Pressure......... Yes ☐ No ☐
7. Swelling Ankles/Feet .... Yes ☐ No ☐
8. Asthma .... Yes ☐ No ☐
9. Bronchitis/Emphysema .... Yes ☐ No ☐
10. Abnormal Chest X-Ray ....Yes ☐ No ☐
11. Tuberculosis ....Yes ☐ No ☐
12. Oxygen at home ....Yes ☐ No ☐
13. Sleep Apnea History ....Yes ☐ No ☐
14. Use Assistive Devices (CPAP/NPPV) (circle) ..... Yes ☐ No ☐
15. Stroke or TIA.. Yes ☐ No ☐
16. Paralysis (R) (L) .... Yes ☐ No ☐
17. Slurred Speech ....Yes ☐ No ☐
18. Difficulty Swallowing ....Yes ☐ No ☐
19. Digestive Problems (GERD) ....Yes ☐ No ☐
20. Blood Vessel Disease (Phlebitis, etc)..................Yes ☐ No ☐
21. Abnormal Bleeding Tendencies (bone marrow disease, platelet abnormality, bleeding disorder, family history of bleeding disorder, blood clots) .... Yes ☐ No ☐
22. Are you on or have you ever had blood thinners...Yes ☐ No ☐
23. Blood Disease (anemia) ....Yes ☐ No ☐
24. Seizures/Epilepsy ....Yes ☐ No ☐
25. Numbness of Arms and/or Legs ....Yes ☐ No ☐
26. Muscle Weakness ....Yes ☐ No ☐
27. Fractured: ☐ Facial Bones ☐ Neck ☐ Back ......Yes ☐ No ☐
28. Joint Replacements ....Yes ☐ No ☐
29. Back Trouble ....Yes ☐ No ☐
30. Glaucoma/Cataracts ....Yes ☐ No ☐
31. Mononucleosis ....Yes ☐ No ☐
32. Hepatitis A, B or C/Cirrhosis/Liver Disease................Yes ☐ No ☐
33. Kidney Disease (ESRD, CRI)/Dialysis......................... Yes ☐ No ☐
    Schedule _____________________
34. Diabetes ....Yes ☐ No ☐
35. Sickle Cell Disease ....Yes ☐ No ☐
36. Positive HIV/AIDS Blood Test .... Yes ☐ No ☐
37. Cancer / Location ....Yes ☐ No ☐
38. Chemo or radiation within last 3 months .... Yes ☐ No ☐
39. Arthritis .... Yes ☐ No ☐
40. Thyroid Problems ....Yes ☐ No ☐
41. Motion Sickness .... Yes ☐ No ☐
42. Smoker or Former Smoker? .... Yes ☐ No ☐
    Former - Year Quit _______
    Current - How much ___________
43. Alcohol Use/How often? _________________ .... Yes ☐ No ☐
44. Recreational Drug Use (Street Drugs) ....Yes ☐ No ☐
45. Immunizations: ☐ Tetanus ☐ Hep A ☐ Hep B ☐ Flu Shot _______ (Date) ☐ Pneumonia _______ (Date)
46. Are you pregnant/lactating (circle) .... ☐ NA Yes ☐ No ☐
    Last Menstrual Period __________________
47. Any body piercing? ....Yes ☐ No ☐
48. Any false or loose teeth, bridges? (circle..) ....Yes ☐ No ☐
49. Wear contact lenses/glasses? (circle) ....Yes ☐ No ☐
50. Have you donated blood to yourself? ....Yes ☐ No ☐
51. Have you ever had a blood transfusion? ....Yes ☐ No ☐
52. Do you object to a blood transfusion? ....Yes ☐ No ☐
53. Any cuts, bruises, sores or rashes ....Yes ☐ No ☐
54. Any reaction to latex, tape, gloves or elastic ....Yes ☐ No ☐
55. Have you ever had anesthesia? .... Yes ☐ No ☐
    Any abnormal reactions to anesthetics? ....Yes ☐ No ☐
57. Relatives with abnormal reactions to anesthetics? Yes ☐ No ☐
58. Any other medical illnesses (list)_______________
____
____

Patient Label
Name: ________________
DOB: _________________

OneCore Health

PATIENT HISTORY QUESTIONNAIRE

List previous surgical/invasive procedures (type and date):

1. ____ 4. ____
2. ____ 5. ____
3. ____ 6. ____

Allergies (drug and food) Please describe reaction of each:

☐ No known allergies

1. ________________________ Reaction _______________ 5. _____________________ Reaction _______________
2. ________________________ Reaction _______________ 6. _____________________ Reaction _______________
3. ________________________ Reaction _______________ 7. _____________________ Reaction _______________
4. ________________________ Reaction _______________ 8. _____________________ Reaction _______________

Sleep Apnea Survey (OSA) ☐ NA – Patient has been previously diagnosed with sleep apnea

1. Do you snore loudly (louder than talking or loud enough to be heard through a closed door)?..........................Yes ☐ No ☐
2. Do you often feel tired, fatigued or sleepy during the daytime?..........................Yes ☐ No ☐
3. Has anyone ever observed you stop breathing during your sleep?..........................Yes ☐ No ☐
4. Do you have or are you being treated for high blood pressure?..........................Yes ☐ No ☐
5. Are you over 50 years of age?..........................Yes ☐ No ☐
6. Do you wear a shirt with a collar size of large or extra-large? ....Yes ☐ No ☐
7. Are you male? ....Yes ☐ No ☐
8. Do you have regular insomnia?..........................Yes ☐ No ☐
9. Are you overweight by 50 pounds or more? (BMI 35 or greater) *If unsure leave blank*..........................Yes ☐ No ☐
10. Have you ever been diagnosed with Sleep Apnea? ....Yes ☐ No ☐

If **YES**: ☐ wears CPAP ☐ prescribed CPAP but do not use it ☐ not prescribed CPAP

Patient Signature ____ **Date** ____________

PATIENTS – DO NO WRITE BELOW THIS SECTION – PAT Staff Use Only

☐ OSA – Low Risk = Yes to 0-2 Questions

Total "YES": ___

☐ OSA- Moderate Risk = Yes to 3-4 Questions

☐ OSA High Risk = Yes to 5-8 Questions or Yes to 2 or more (Q1-4) + Male
Yes to 2 or more (Q1-4) + BMI >35
Yes to 2 or more (Q1-4) + Collar Size is large
Yes to Q #10

Patient Label
Name: _______________
DOB: ________________

1. Allergies and Reaction: ☐ No Known Allergies or ____

____

Food Allergies: ☐ No Known Allergies or ____

Include topicals, ointments, liquids, parenterals, oxygen, inhalers, drops, over the counter medications, herbals & vitamins

Provider Only Check meds to be cont'd while in Hospital with overnight stay	**2. Medication Name**	**Dosage** (Also include any variables. For example 15mg 1-2 tabs)	**Route** (by mouth, injection, topical, inhalation, IV, etc…)	**Frequency** (How often?)	**Indication** (What does the patient take the medication for?)	*Nursing Only* Validated with Pharmacy or Bottles Inpt Only	*Pre-Op Only* **Date/Time of Last Dose** *(to be done on date of surgery)*	*Provider Only* **On Discharge** Check Meds to be continued at Home
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N
❑Y ❑N								❑Y ❑N

3. Source of Information:

☐ No home medications ☐ Patient

☐ Medication List ☐ Patient's Family ☐ Medication bottles ☐ Old Chart

☐ Nursing Home ☐ Doctor's Office ☐ Pharmacy ☐ Other: ____________________

4. Medication History Initiated By: ______________________________ Date/Time: ________________

5. Physician Signature: ______________________________ Date/Time: ________________

6. Medication History Updated by: ______________________________ Date/Time: ________________

Medication History Updated by: ______________________________ Date/Time: ________________

☐ Medications have been identified appropriately by inpatient nursing staff *(Inpatients only)* ☐ List sent to Pharmacists.

7. Additional Home Medications for Patient Discharge. To be completed by hospital staff at discharge

Use more than one form if necessary to complete discharge meds

Medication	Dose/Route/Frequency/Comments	Next Dose?	Rx Given?
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

8. ☐ ***Copy given to patient or significant other by***: Date/Time:

OneCore Health

Medication History/Reconciliation Form

Place patient label here. If not available, complete:

Patient Name:

DOB:

DOS:

Revised 1/2009, 5/28/09, 3-4-10, 3/15, 7/15, 9/16, 4/17