Patient Name:

CURRENT MEDICATIONS: Prescription

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

SURGICAL HISTORY

Year	Surgery

ALLERGIES: Medication/Food/Other

☐ None Known ☐ Latex

Reaction:

Reaction:

Reaction:

HEALTH HISTORY

Height: _____ Weight: _____

Last Menstrual Period: _____

	Yes	No		Yes	No
Anemia	☐	☐	Hepatitis-Type:	☐	☐
Asthma	☐	☐	Immunodefiency	☐	☐
Arthritis Pain	☐	☐	Disease		
Bladder	☐	☐	Kidney	☐	☐
Infection			Disease/Stone		
Bleeding	☐	☐	Liver Problems	☐	☐
Problems			Migraines	☐	☐
Cancer	☐	☐	Sickle Cell	☐	☐
Chest Pain	☐	☐	Sleep Apnea	☐	☐
Angina			Stomach	☐	☐
Cholesterol	☐	☐	Problems		
COPD	☐	☐	Stroke	☐	☐
Depression	☐	☐	Thyroid Disease	☐	☐
Diabetes	☐	☐	Tuberculosis	☐	☐
Difficulty with			Tubes		
Hearing	☐	☐	Colostomy	☐	☐
Vision	☐	☐	Foley	☐	☐
Fainting	☐	☐	JP drain	☐	☐
Heartburn/acid	☐	☐	Nephrostomy	☐	☐
Reflux			PICC line	☐	☐
Heart Disease	☐	☐	Portacath	☐	☐

PEDIATRICS ONLY

Immunizations: ☐ 2mo. ☐ 4mo. ☐ 6mo. ☐ 18 mo. ☐ 4-6yrs. ☐ Last immune. @ 15 yrs.

Diet: ☐ Breast ☐ Formula, Type _____ ☐ Milk ☐ Junior foods ☐ Table food ☐ Special diet: _____

SPECIAL NEEDS

Artificial:	Yes	No	Dentures:	Yes	No
Limb	☐	☐	Full	☐	☐
Eye	☐	☐	Partial	☐	☐
Contacts	☐	☐	Loose teeth	☐	☐
Glasses	☐	☐	Braces/Caps	☐	☐
Lense Implant	☐	☐	Hearing Aids	☐	☐

SAFETY

Do you have a history of:	Yes	No		Yes	No
Unsteady walk/balance	☐	☐	Falling	☐	☐
Use walker/cane/crutch	☐	☐	Use brace	☐	☐

ANESTHESIA HISTORY

Have you or a blood relative had a reaction to general or local anesthesia? ☐ Yes ☐ No If yes, please explain:

_____

PSYCHOSOCIAL HISTORY

Religious Preferences: _____

Primary Language Spoken: _____

Do you:	Yes	No	Amount
Smoke/use tobacco	☐	☐	_____
Drink beer/alcohol	☐	☐	_____
Caffeine Intake	☐	☐	_____

****Domestic Violence Risk Screening**

(> 2"Yes" refer to Nursing Supervisor <24 hours)

	Yes	No
1) STRESS/SAFETY Should I be concerned for your safety?	☐	☐
2) AFRAID/ABUSE: Are there any personal situations that you have been in that you have felt afraid?	☐	☐
3) FRIENDS/FAMILY: Does someone need to be aware that you have been threatened/hurt?	☐	☐
4) EMERGENCY PLAN: Do you need help in locating a safe place?	☐	☐

PAIN SCREENING

Inpatient Admissions only:	Yes	No
Do you have any ongoing pain problems?	☐	☐
Do you have pain now?	☐	☐
Outpatient Admissions only:	Yes	No
Is your pain the reason for your visit today?	☐	☐
Are you under a physician's care for pain?	☐	☐

Rate your pain ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

This page was completed by : ☐ Patient ☐ Significant Other

Name: _____ Relationship: _____

RELATIVE/RIDE INFORMATION:

Name and phone number of person 18 years old or older who will be taking you home from surgery/hospital?

Name: _____

Phone number: _____

FOLLOW UP CALL INFORMATION:

What number can you be reached at the day after you return home? _____

☐ **MD Reviewed meds prior to procedure**

Prep Central: BP _____ P: _____ R: _____

Nurse Reviewed: _____