

**PRE-PROCEDURE and ADMISSION SCREENINGS**

**PATIENT INFORMATION**

Home phone \_\_\_\_\_ Work \_\_\_\_\_ Local/cell number \_\_\_\_\_  
 Would it be best to call you at  home  work Can we leave a message?  Yes  No  
 Patient e-mail address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Primary care physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

**ADMISSION SCREENINGS**

ALLERGIES	Reaction	Reaction	Other Allergies	Reaction
<input type="checkbox"/> No known		<input type="checkbox"/> Fish/shellfish	_____	_____
<input type="checkbox"/> Penicillin	_____	<input type="checkbox"/> Avocado	_____	_____
<input type="checkbox"/> Sulfa	_____	<input type="checkbox"/> Chestnuts	_____	_____
<input type="checkbox"/> Contrast dye	_____	<input type="checkbox"/> Banana	_____	_____
<input type="checkbox"/> Latex	_____	<input type="checkbox"/> Kiwi	_____	_____

**Pain**  
**Using the pain scale below, how bad is your pain today?**  
 0 1 2 3 4 5 6 7 8 9 10  
 No Mild Mod Severe Very Worst  
 Pain Pain Pain Pain Severe Pain

**Blood Administration**  
**Do you refuse a blood transfusion?**  No  Yes

**Communication/Learning**  
**Check all that apply**  
 Hearing impaired  
 Wears hearing aid  
 Visually impaired  
 Wear glasses/contacts  
 Speak English  
 Understand English  
 Read English  
 Speak Spanish  
 Other language \_\_\_\_\_  
 Learns best by  Seeing  Hearing  Doing

**Functional Screening**  
**I have problems**  
 Walking  
 Transferring in/out of bed/toilet  
 Bathing/dressing  
 Toileting  
 Taking medications  
 Communicating wants/needs  
 Understanding/memory  
 Swallowing  
 Falling  
 No items apply

**Nutrition Screening**  
 Unable to eat  Pregnant  Breast-feeding  
 > 5 lb wt loss last 3 months  
 Trouble swallowing or chewing problems  
 Special diet \_\_\_\_\_  
 No items apply

**Psycho/Social**  
**Are you presently seeing a mental health worker for counseling?**  No  Yes

**Do you smoke?**  No  Yes **Ever smoked?**  No  Yes  
 If so, \_\_\_\_\_ packs / per day / for \_\_\_\_\_ yrs  
**Quit in the last 12 months**  No  Yes  
**Are you interested in information to help you quit smoking?**  No  Yes

**Do you drink alcohol?**  No  Yes  
 how much \_\_\_\_\_ how long \_\_\_\_\_

**Are you currently using recreational drugs?**  
 No  Yes

**Have you ever been abused physically, verbally or sexually harmed or felt threatened by someone at home/work?**  
 No  Yes You will be given a brochure if YES is checked

**Spiritual**  
**Is there anything we need to know about your values / beliefs in order to provide good care for you?**  
 No  Prayer  Sacraments  Religious reading  
 To see my own faith representative  Dietary needs  
 Blood/drug restrictions

**Do you have any body piercing?**  No  Yes If so, where \_\_\_\_\_  
**Have you ever been told you have an infection that is resistant to antibiotics?**  No  Yes  
 If yes,  MRSA  VRE  other \_\_\_\_\_  Don't know  
 If patient answers yes, send notification to UCH Infection Control Team

