

PRE-PROCEDURE and ADMISSION SCREENINGS

PATIENT INFORMATION			
Home phone _____		Work _____ Local/cell number _____	
Would it be best to call you at <input type="checkbox"/> home <input type="checkbox"/> work Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Home address _____		City _____ State _____	
E-mail _____			
Primary care physician _____		Phone _____ Fax _____	
Emergency contact _____		Relation _____ Phone _____	
ADMISSION SCREENINGS			
ALLERGIES	Reaction	Reaction	Other Allergies
<input type="checkbox"/> No known		<input type="checkbox"/> Contrast dye _____	<input type="checkbox"/> Banana _____
<input type="checkbox"/> Penicillin _____		<input type="checkbox"/> Fish/shellfish _____	<input type="checkbox"/> Kiwi _____
<input type="checkbox"/> Sulfa _____		<input type="checkbox"/> Avocado _____	
<input type="checkbox"/> Latex _____		<input type="checkbox"/> Chestnuts _____	
Communication		Psycho/Social	
Check all that apply <input type="checkbox"/> Speak English <input type="checkbox"/> Understand English <input type="checkbox"/> Read English <input type="checkbox"/> Speak Spanish Other language _____		Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes Ever smoked? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, _____ packs / per day / for _____ yrs Quit in the last 12 months <input type="checkbox"/> No <input type="checkbox"/> Yes Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes how much _____ how long _____ Are you currently using recreational drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you have any body piercing? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, where _____	
Have you ever been told you have an infection that is resistant to antibiotics? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> other _____ <input type="checkbox"/> Don't know If patient answers yes, send notification to UCH Infection Control Team			
PREPROCEDURE SCREENING			
Have you or anyone in your family had problems with general anesthesia? <input type="checkbox"/> no <input type="checkbox"/> yes If yes, describe <input type="checkbox"/> you <input type="checkbox"/> family member _____ _____	<input type="checkbox"/> trouble breathing lying flat <input type="checkbox"/> asthma <input type="checkbox"/> shortness of breath <input type="checkbox"/> shortness of breath on exertion <input type="checkbox"/> lung disease <input type="checkbox"/> emphysema <input type="checkbox"/> use oxygen <input type="checkbox"/> sleep apnea <input type="checkbox"/> use CPAP <input type="checkbox"/> told I snore <input type="checkbox"/> frequently tired during the day <input type="checkbox"/> told I stop breathing when asleep <input type="checkbox"/> high blood pressure <input type="checkbox"/> take blood pressure medication <input type="checkbox"/> irregular heart beats <input type="checkbox"/> heart attack <input type="checkbox"/> heart surgery <input type="checkbox"/> blood clots <input type="checkbox"/> abnormal EKG <input type="checkbox"/> high cholesterol <input type="checkbox"/> chest pain /pressure/angina Explain- _____ <input type="checkbox"/> heart murmur	<input type="checkbox"/> abnormal heart stress test When _____ Where _____ <input type="checkbox"/> abnormal heart ultrasound When _____ Where _____ <input type="checkbox"/> pacemaker/internal defibrillator → Type/model of pacemaker _____ Are you <input type="checkbox"/> Under the care of a heart doctor Name _____ Phone # _____ <input type="checkbox"/> No items apply List past surgeries/medical issues _____ Date _____ _____ Date _____ _____ Date _____ _____ Date _____ _____ Date _____	
Do you have or have you had? <input type="checkbox"/> problems bending your neck <input type="checkbox"/> problems opening your mouth <input type="checkbox"/> head injury <input type="checkbox"/> seizure disorder <input type="checkbox"/> stroke / TIA ("mini stroke") <input type="checkbox"/> liver disease <input type="checkbox"/> hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> diabetes <input type="checkbox"/> kidney disease <input type="checkbox"/> thyroid disease <input type="checkbox"/> rheumatoid arthritis <input type="checkbox"/> osteoarthritis <input type="checkbox"/> GERD/reflux/heartburn <input type="checkbox"/> cancer –what kind _____	Important note- Please see back side to list your medications →→→	Height _____ Weight _____	

