Today's date: ___/___/___ **Patient Name:** _____ **Form completed by:** _____
Date of procedure:___/___/___ Procedure:_____ Surgeon: _____
Primary Language: ☐ English ☐ Spanish ☐ Other:_____ Interpreter needed: ☐ Yes ☐ No
Reason for admission in your own words:_____
I best learn by: ☐ Hearing ☐ Reading ☐ Watching ☐ Doing Primary care physician: _____
List all previous surgeries and / or hospitalizations and approximate year: _____
_____
_____

Height:_____ **Weight:**_____ **Allergies / Reaction** _____
Current Medications: ☐ None ☐ See attached medication list.

Medication/Strength	# Tabs	How often	Why are you taking it?

HEALTH HISTORY (Please Indicate Yes or No by checking the appropriate box or boxes, & filling in blanks)

YES NO SOCIAL

☐ ☐ Do you drink alcohol? How much_____ Last drink:___/___/___
☐ ☐ Do you or did you smoke? How long:_____ How much:_____ Quit? ☐ No ☐ Yes When:___/___/___
☐ ☐ Do you or did you chew tobacco? How long:_____ Quit? ☐ No ☐ Yes When:___/___/___
☐ ☐ Do you use marijuana? Medical reason?_____ How often?_____ Last used date:___/___/___
☐ ☐ Do you use recreational drugs? What?_____ How often?_____ Last used date: ___/___/___
☐ ☐ Have you taken any herbal medications, mega vitamins, weight loss medications, or homeopathic remedies in the past month?

CARDIOVASCULAR (Date of last EKG: ___/___/___, Where:_____)

☐ ☐ Heart disease
- ☐ High blood pressure ☐ On blood pressure meds ☐ Recent change in meds ☐ Controlled ☐ No meds
- ☐ Chest pain ☐ With activity ☐ At rest, Pain relieved by ☐ Stopping activity ☐ Nitroglycerine
- ☐ Heart attack ☐ How many_____ Dates:___/___/___
- ☐ Open heart surgery Date:___/___/___ ☐ Angioplasty Date:___/___/___ ☐ Stents Date: ___/___/___
- ☐ Congestive Heart failure (CHF) ☐ Irregular heart beat or heart rhythm
- ☐ Heart valve problems ☐ Heart murmur ☐ Rheumatic fever ☐ Mitral valve prolapse
- ☐ Heart valve surgery Date:___/___/___ ☐ Aortic valve ☐ Mitral valve ☐ Other: _____
- ☐ Stress test Date:___/___/___ ☐ Cardiac ECHO Date:___/___/___ ☐ Heart catheterization Date___/___/___
- ☐ Widening of aorta / Aortic aneurysm ☐ Peripheral vascular disease
- ☐ Pacemaker ☐ Defibrillator / AICD Last tested:___/___/___

☐ ☐ Stroke? Date:___/___/___ ☐ Paralysis or weakness related to stroke:_____

PULMONARY (LUNG) (Date of last chest X-ray:___/___/___, Where:_____)

☐ ☐ Do you use oxygen? ☐ At all times ☐ Only with activity ☐ Only at night
☐ ☐ Lung problems? ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Cancer ☐ Pneumonia ☐ Lung surgery
☐ Recent cold or flu ☐ Productive or bloody cough ☐ TB ☐ Shortness of breath ☐ Other: _____

INFECTIOUS DISEASE

☐ ☐ Exposure to anyone with a contagious disease? ☐ Hepatitis ☐ Flu ☐ Chicken Pox ☐ HIV

ENDOCRINE

☐ ☐ Diabetes? When was diagnosis made:___/___/___ Method of control: ☐ Diet ☐ Oral medication ☐ Insulin
☐ ☐ Thyroid disease? ☐ Hypothyroid ☐ Hyperthyroid ☐ On medication ☐ No medication Last test Date:___/___/___

Please continue on side 2 of form

PATIENT IDENTIFICATION

BARTON MEMORIAL HOSPITAL
PRE-ADMISSION PATIENT HEALTH HISTORY
(To be completed by patient)
Side 1

HEALTH HISTORY

Continued Side 2

YES NO **GI / RENAL**

☐ ☐ Hepatitis? ☐ Type A ☐ Type B ☐ Type C ☐ Jaundiced ☐ Liver disease Last liver function test Date:___/___/___

☐ ☐ Digestive/Stomach problems? ☐ Heartburn/Indigestion ☐ GERD / Reflux ☐ Hiatal hernia ☐ Change of bowel habits ☐ Ostomy ☐ Overweight ☐ Difficulty with chewing or swallowing

☐ ☐ Renal (Kidney) problems? ☐ Dialysis ☐ CAPD Date of last dialysis:___/___/___

ONCOLOGY

☐ ☐ Cancer? What type: _____ Treatment: ☐ Chemo ☐ Radiation Date:___/___/___

HEMATOLOGY

☐ ☐ Bleeding? (prolonged or unusual bleeding from cuts, bruises, nose bleeds, teeth extractions, surgery)

☐ ☐ Blood clot problems? ☐ Leg ☐ Arm ☐ Lung Date:___/___/___

☐ ☐ Anemia? ☐ Transfusions Date:___/___/___

☐ ☐ Sickle Cell Disease / Thalassemia?

☐ ☐ Do you take blood thinners?

☐ ☐ Do you take aspirin or analgesics regularly?

ANESTHESIA

☐ ☐ Obstructive sleep apnea? ☐ Use CPAP ☐ Use oxygen ☐ Significant snoring ☐ Stop breathing while sleeping ☐ Feel tired or sleepy during daytime ☐ Neck size greater or equal to 16?

☐ ☐ Do you or a family member have a history of high fever after anesthesia? (Malignant Hyperthermia)

☐ ☐ Have you been told that it is difficult to place a breathing tube in your throat (intubate)?

☐ ☐ History of severe nausea and vomiting after anesthesia?

☐ ☐ Do you have a history of severe reaction to anesthesia?

☐ ☐ Any possibility you could be pregnant? ☐ If yes, Due date:___/___/___ ☐ if no, Date of last period:___/___/___ ☐ Breast feeding

☐ ☐ Do you have religious or other objections to blood transfusions?

OTHER

☐ ☐ Hearing problems? ☐ Hard of hearing ☐ Wear hearing aids ☐ Right ☐ Left

☐ ☐ Dentures, Partials, Capped teeth, Loose teeth or Orthodontic appliances? (circle) _____

☐ ☐ Eye problems? ☐ Glaucoma ☐ Cataracts ☐ Blind ☐ Wear glasses ☐ Wear contacts

☐ ☐ Seizure Disorder? When was your last seizure?___/___/___ Current Therapy _____

☐ ☐ Chronic headaches or blurred vision? _____

☐ ☐ Do you have a history of acute or chronic pain? Where: _____

☐ ☐ Are you having pain now? Pain level:_____ Goal:_____ (Use Pain Scale: No pain = 0 — 10= Worst pain) Where?_____

☐ ☐ Problems with nerves, muscles or skin? _____

☐ ☐ Steroid therapy in the last 12 months? (cortisone, prednisolone) _____

☐ ☐ Physical limitations? ☐ Wheelchair ☐ Cane ☐ Crutches ☐ Prosthesis ☐ Other _____

☐ ☐ Replacement joints or metal under your skin? Where: _____

☐ ☐ Psychiatric treatment or disorder? _____

☐ ☐ Advance directive or living will?

CHILDREN ONLY

Immunizations Current? ☐ Yes ☐ No Nutrition ☐ Bottle ☐ Cup ☐ Breast

Premature at birth? ☐ Yes ☐ No

For office use only

Reviewed by nurse: _____ RN Date:_____ Time:_____

Reviewed by surgeon: _____ MD Date:_____ Time:_____

Consultation Needed ☐ Yes ☐ No ☐ Refer to anesthesiologist

METS score =_____ BMI =_____ ☐ BMI greater than 35 ☐ HTN ☐ Male ☐ Age over 50

PATIENT IDENTIFICATION

BARTON MEMORIAL HOSPITAL
PRE-ADMISSION PATIENT HEALTH HISTORY
(To be completed by patient)
Side 2

8/23/12
B045 / 7760-D001
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File Specification Information

Document Size	Gripper / Lock-Up	Stub	Imprint
8.5 x11	All	N	N
Punch	**Numbering**	**Binding**	**Registering Plys**
T2	N	N	N
Screens	**Backer(s) and Percentage**		
N	tumble-fv-differs		
Color(s)			
Blk			

File Information / Master Page

12 pt. type

Other