ST. MARY'S MEDICAL CENTER

Name	Birthdate	Phone Number:

Dear Patient and Family,

Please answer the following questions. Your answers will help your health care team plan and give care to you or your significant other. A nurse will review this form with you after it is filled out. If you are unclear on any questions or need assistance, leave it blank and the nurse will assist you.

Thank you,
St. Mary's Medical Center

NURSING USE ONLY
Information provided by: _____

- ☐ Patient
- ☐ Nursing staff
- ☐ Family member/friend
- ☐ Other

Date: _____

Nurse's Signature: _____
NOTE: *Protocol may require testing

PATIENT LEFT COLUMN ONLY
INFORMATION ABOUT THE PATIENT

1. Why are you coming to the medical center? _____
   _____
   _____
   Age _____ Height _____ Weight _____

2. Do you have any allergies/reactions to drugs, food, latex (rubber), dye or environmental?
   ☐ Yes, please list ☐ No

ALLERGY TYPE OF REACTION

_____
_____
_____
_____
_____

3. List medications currently taken (include over the counter non-prescription meds, herbs, and vitamins).

* DRUG (Medicine) DOSE (Strength) How Often

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

NURSING ASSESSMENT/ INTERVENTION

Procedure: _____
_____
Date/Doctor: _____
_____

PRIMARY PHYSICIAN
_____

Y	N	
☐	☐	Consent _____
☐	☐	H&P _____
☐	☐	Labs _____
☐	☐	CXR _____
☐	☐	EKG _____
☐	☐	Stress Test _____

_____

☐ Patient instructed not to take aspirin, NSAID 1 week prior to surgery.

☐ Office instructed to take the following meds: _____
_____
_____
_____
_____
_____
_____

* NOTE: Chem 7 may be required by protocol if taking diuretics or digitalis

OUTPATIENT ASSESSMENT

Adopted Date:
Revised Date: 10/02; 6/04; 11/04
Reviewed Date:

«LastName» , «FirstName»
«PatientNumber» / «AdmitDate»
«Gender» / «BirthDate»
«PatientAddress1» / *«PatientNumber»*
«SSN» / «Room» / «MedicalRecordNumber»

4. Do you have any of the following: (present and past history)

Y	N		
☐	☐	*	High/low blood pressure
☐	☐	*	Chest pain
☐	☐	*	Heart attack
☐	☐	*	Heart skips beats/races
☐	☐	*	Heart failure
☐	☐	*	Circulation problems
☐	☐	*	Passing out spells
☐	☐	*	Blood clots
☐	☐	*	Lung problems/disease
☐	☐	*	Shortness of breath
☐	☐		Wheezing
☐	☐	*	Emphysema/Asthma (COPD)
☐	☐	*	Black lung
☐	☐	*	Asbestosis
☐	☐	*	Pneumonia
☐	☐	*	Bronchitis
☐	☐		Cold within last week
☐	☐	*	Vomiting
☐	☐	*	Heartburn
☐	☐		Reflux (food/liquid comes back up in throat)
☐	☐		Ulcers
☐	☐		Hiatal hernia
☐	☐	*	Kidney disease
☐	☐	*	Urinary tract infection
☐	☐		Kidney stones
☐	☐		Bowel problems
☐	☐	*	Diarrhea/Constipation
☐	☐		Diabetes (high sugar)
☐	☐		Thyroid problems
☐	☐		Stroke/Paralysis
☐	☐		Seizures
☐	☐		Head injury
☐	☐		Neck/back problems
☐	☐		Arthritis
☐	☐	*	Free bleeder not related to medication
☐	☐		Liver problems/Hepatitis/Cirrhosis/Jaundice
☐	☐		Anemia
☐	☐		Have you ever had a blood transfusion?
☐	☐		If yes, did you have a reaction to that transfusion?
☐	☐		Chicken pox? If yes, when? _____
☐	☐		Tuberculosis (TB), positive TB test, unexplained weight loss, temperature or coughing up blood, mucus for 3 weeks or more, night sweats
☐	☐		Cataracts/glaucoma
☐	☐		Ear infections

	Y	N
Heart murmur	☐	☐
Mitral Valve prolapse	☐	☐
Rheumatic fever	☐	☐

If yes to any of the above, do you require prophylactic antibiotics? ☐ ☐

Do you have an AICD/pacer: ☐ Yes ☐ No

If yes notify the OR

Date/time/person notified

_____

_____

Any Yes Answers respond below:

* Note may require testing by protocol.

«LastName» , «FirstName»
«PatientNumber» / «AdmitDate»
«Gender» / «BirthDate»
«PatientAddress1» / *«PatientNumber»*
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4. Do you have any of the following: **CON'T** (present and past history)

Y / N

- ☐ ☐ History of cancer? If yes, type _____
- ☐ ☐ Have you smoked in the past 12 months. If so, when did you stop? _____
- ☐ ☐ Do you smoke? If yes, how much and how long? _____
- ☐ ☐ Do you use alcohol or illegal drugs? If yes, what/ amount? _____
- ☐ ☐ * Chance of pregnancy? Last menstrual period _____

5. List your previous surgeries, dates, hospitals below:

Surgery	Date	Hospital

6. Type Anesthesia received in the past:
   - ☐ General (put to sleep) ☐ Epidural
   - ☐ Spinal
   - ☐ Other

Obtain old record, report the necessary information to the anesthesia department.

7. Have you or any family member had trouble/problems with anesthesia: ☐ Yes ☐ No
   If yes, check what applies:
   - ☐ nausea/vomiting
   - ☐ high temperature after surgery
   - ☐ memory loss due to anesthesia

8. Do you have anyone to help you when you get home?
   ☐ Yes ☐ No
   Person to be notified regarding discharge plans or in case of emergency.

_____
Name (Relationship) Phone(home) (Work)

_____
Name (Relationship) Phone(home) (Work)

Verify responsible adult for 24 hours and a driver to accompany patient.

9. Do you live: ☐ Alone ☐ With Spouse ☐ Other _____

Do you have (check all that apply)
☐ Indoor plumbing ☐ Phone ☐ Stairs ☐ Electricity
☐ Gas ☐ Heat

10. Do you have any of the following?
☐ Hearing aids L/R ☐ Glasses ☐ Dentures upper/lower
☐ Partial plate upper/lower ☐ Bridges/caps/crowns
☐ Chipped/loose teeth ☐ Walker ☐ Cane ☐ Crutches
☐ Wheelchair ☐ Oxygen ☐ Artificial limbs/braces

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12. Do you have any special diet or use dietary supplement? ☐ Yes ☐ No If yes, list:_____ _____ _____ _____	
13. Are you or anyone in your home being hurt, hit, threatened, frightened or neglected? ☐ Yes ☐ No	If yes, initiate social service referral and document: Date/time: _____ Name: _____ Control Number: _____
14. Do you think you might have trouble: (please check all that apply): ☐ Managing your care (bathing, cooking, taking meds, care at home after discharge) ☐ Paying for medications ☐ Paying for hospitalization ☐ Having someone to care for you at home ☐ Getting a ride for discharge/return appointment ☐ I do not expect any problems.	Refer to social services or patient accounts representative: Date/time: _____ Name: _____ Control Number: _____
15. Advanced Directives Y / N ☐ ☐ Have you made arrangements for how medical treatment should be applied or withheld if you were to become unable to make your health care decisions? (Advance Directives). ☐ ☐ Are these arrangements in writing? (If no, provide packet) ☐ ☐ Have you made arrangements for another person(s) to make medical decisions on your behalf if you are unable to communicate. ☐ ☐ Are these arrangement in writing? (If no, provide packet)	If answered yes informed to bring copy for chart. If answered no would you like to execute either form at this time? ☐ Yes ☐ No Admission packet with forms given to patient. Trusted representative _____ Intent _____ *** If the patient is confused or comatose and no valid medical power of attorney exists, the physician is to be notified regarding possible surrogate appointment. MD Notified: _____ Date/Time: _____

«LastName» , «FirstName»
«PatientNumber» / «AdmitDate»
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)iabetic Assessment:

ıre you diabetic? ☐ YES, (If YES complete the following questions. ☐ NO

Do you know how to manage high blood sugar?	☐ Yes ☐ No, explain _____	☐ Not applicable
Do you know how to manage low blood sugar?	☐ Yes ☐ No, explain _____	☐ Not applicable
Do you know how to take your diabetes pills?	☐ Yes ☐ No, explain _____	☐ Not applicable
Do you take your insulin regularly?	☐ Yes ☐ No, explain _____	☐ Not applicable
Are your injections given without problem?	☐ Yes ☐ No, explain _____	☐ Not applicable
Are your injection sites changed regularly?	☐ Yes ☐ No, explain _____	☐ Not applicable
Do you check your feet daily for problems?	☐ Yes ☐ No, explain _____	☐ Not applicable
Do you know what to do about your diet, medications when sick?	☐ Yes ☐ No, explain _____	☐ Not applicable
Do you know about long term complications of diabetes?	☐ Yes ☐ No, explain _____	☐ Not applicable
Do you need to see a dietitian for help with meal planning?	☐ Yes ☐ No, explain _____	☐ Not applicable
Do you need to learn to check your blood sugar?	☐ Yes ☐ No, explain _____	☐ Not applicable

Do you need a blood sugar monitor? (Yes requires a Social Service Consult) ☐ Yes ☐ No

Do you need monitor supplies? (Yes requires a Social Service Consult) ☐ Yes ☐ No

Do you need syringes? (Yes requires a Social Service Consult) ☐ Yes ☐ No

NURSING USE ONLY

Nutrition State:

☐ No nutritional risk	☐ Oral lesions	☐ TF or TPN, PPN	☐ Chewing/mouth problems
☐ Early satiety	☐ Poor PO 5 days/more	☐ Taste change	
☐ No teeth	☐ Swallowing difficulty	☐ Unintentional wt. loss > l0lbs.	
☐ Poor dentition	☐ Chemo/radiation	☐ Avoids certain foods	

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