ASH Nurse Navigator Office: 970-385-2356

Pre-Surgical Patient Intake

Patient Information

Name: ____ DOB: ___________ Age: _______

Height: _______ Weight: _______ Best Phone Number to Reach You: ______________________

Alternate Number: __________________

Do you have an Advanced Directive? □Advanced Directive □Living Will □Power of Attorney □None

Surgery Information

Date of Surgery: ____________ Surgeon: ______________ Type of Surgery: ___________

Caregiver Information

You must have a ride to take you home and stay with you overnight after surgery.

Notify the Nurse Navigator Office if you have any questions.

Name: _________________________Relationship: _____________Phone number: _____________

Name: _________________________Relationship: _____________Phone number: ______________

Surgical History

Date of Previous Surgery	Type of Surgery	Surgeon	Facility	List Any Complications

Anesthesia Screening

Have you ever had anesthesia? □ YES □ No

Have you had problems w/ anesthesia in the past? □ YES □ No

If yes, describe (confusion, vomiting, delirium): ____

____

Do you have a family history of anesthesia problems? □ YES □ No

If yes, describe (Fever, Malignant Hyperthermia, Death) ___________________________________

____

Primary Care Provider

PCP Name	PCP Phone	Date of Last Visit

Specialist Provider(s) (Cardiologist, Pulmonologist, etc.)

Specialist Name	Specialist Phone	Date of Last Visit

Recent Diagnostic Tests (Lab work, ECG, X-Ray

Date of Testing	Testing Facility

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Pre-Surgical Patient Intake

Allergies/Medication Sensitivities

Diagnosed Allergy:	Type of Reaction:	Medication:	Reaction:

Current Level of Activity

□ None (sedentary) □ Light (light housework) □ Moderate (walking) □ Active (biking, hiking)

How Often? □Daily □1-2 x/wk □ 3-5 x/wk

Walking/Activity Assistance: □ Independent □ Partial Assist □ Full Assist □ Non-ambulatory

□ Cane □ Crutches □ Walker □ Wheelchair

Social History

Tobacco use: □ Never Smoker □ Former Smoker □ Current Smoker Years used: _________

Packs per day: _____ Year Quit:__________

Alcohol use: □ None □Rare □Occasional □Frequent (drinks/day): ______________

Marijuana use: □ None □ Rare □Occasional □Frequent List Type: ______________________________

Other Drug use (please specify): ____

Do you feel safe at home? □ Yes □No

Immunization History

Pneumonia: □ YES □ No Flu: □ YES □ No Tdap: □ YES □ No

Date: _________________ Date: _______________ Date: ________________

Other Immunizations:

Type: __________________ Type: ___________________

Date: __________________ Date: ___________________

Psychiatric Screening

Anxiety/Panic □ YES □ No Depression □ YES □ No

Bipolar/Mania □ YES □ No Schizophrenia □ YES □ No

Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Neurological Screening

Seizures/Epilepsy □ YES □ No Headaches/migraines □ YES □ No

Muscle weakness □ YES □ No Spinal cord abnormality □ YES □ No

Stroke/paralysis/TIA □ YES □ No Dementia/Alzheimer □ YES □ No

Please List Date of Diagnosis and Current Treatment for all Yes Questions:

Sensory Devices

Contacts □ YES □ No Hearing Aides □ YES □ No R or L; Glasses □ YES □ No

____

____

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Pre-Surgical Patient Intake

Cardiovascular Screening

High Blood Pressure	□ YES	□ No	Pacemaker/Defibrillator	□ YES	□ No
Valve prolapse	□ YES	□ No	Coronary Artery Bypass Grafts	□ YES	□ No
Palpitations	□ YES	□ No	Heart attack	□ YES	□ No
Stent(s) (year)	□ YES	□ No	High Cholesterol	□ YES	□ No
Chest pain/angina	□ YES	□ No	Irregular Heart Beat	□ YES	□ No
Angioplasty (year)	□ YES	□ No	Rheumatic fever	□ YES	□ No
Congestive heart failure	□ YES	□ No	Heart murmur	□ YES	□ No

Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Respiratory Screening

Sleep Apnea □ YES □ No

Do you use a CPAP/Bipap? □ YES □ No

If yes, describe (At night? How often? With oxygen?)

____

Emphysema □ YES □ No

Do you use Oxygen? □ YES □ No

If yes, describe (At night? How Often? How many Liters?)

____

Asthma/Wheezing □ YES □ No

Bronchitis/cough □ YES □ No

Allergies/sinusitis □ YES □ No

Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Gastrointestinal Screening

Ulcers □ YES □ No

Reflux/heartburn □ YES □ No

Hiatal Hernia □ YES □ No

Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Endocrine/Kidney/Liver Screening

Diabetes (Type I or II)	□ YES	□ No	Kidney failure	□ YES	□ No
Hepatitis	□ YES	□ No	Dialysis (schedule)	□ YES	□ No
Thyroid (hypo or hyper)	□ YES	□ No			

Please List Date of Diagnosis, Type if applicable, and Current Treatment for all Yes Questions:

____

____

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Pre-Surgical Patient Intake

Musculoskeletal Screening

Arthritis/TMJ □ YES □ No Gout □ YES □ No
Fibromyalgia □ YES □ No Back Pain □ YES □ No
Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Integumentary

Non-healing sores □ YES □ No
Shingles □ YES □ No
Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Cancer

Cancer (type) □ YES □ No If yes, describe (Date Diagnosed, Type, Where in Body)

____

Is your cancer in Remission? □ YES □ No (Date) ____________________________________
Chemotherapy □ YES □ No (Last Treatment) ____
Radiation □ YES □ No (Last Treatment) ____

Bleeding disorders

Blood clots (legs/lungs) □ YES □ No
Hemophilia □ YES □ No

Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Infectious Disease Screening

MRSA □ YES □ No Have you been swabbed or 'cleared' of MRSA? □ YES □ No
Date: ___________ Treated: □ Yes □No Location of MRSA: ______________________________
HIV/AIDS □ YES □ No
Date Diagnosed: _______________ Last Treatment: ____________________________
Current Treatment: ____
TB □ YES □ No Type: □Latent □ Active
Date Diagnosed: ________________Date Treatment Completed: ________________________________
Hepatitis □ YES □ No
Type: A□ B□ C□ Date Diagnosed: __________________
Last Treatment:______________________ Current Treatment: ________________________
C-Diff □ YES □ No Date Diagnosed: ___________________ Treatment: _________________________

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Pre-Surgical Patient Intake

Pediatric-(Pediatric Patients Only)

Premature birth □ YES □ No If yes, describe:

____

Who has custody? ____

Developmental delay □ YES □ No If yes, describe:

____

Other:____

____

Is there anything else we need to know?____

____

____

Home Medication List

Please list below all medications, including over the counter and supplements, that you are currently taking.

Med Name	Strength	Frequency	Route	Reason	Physician Prescribed
**EX: Lisinopril	10mg	2 day	Oral	Blood Pressure	Ciotti

We appreciate you taking the time to fill out this form. It helps us take excellent care of you while at Animas Surgical Hospital.