CONTACT INFORMATION

Date Submitted: 06/04/13

First Name* Sheryl | **Last Name*** Heyniger | MI | **Birthday*** 03/25/1968 | 47

Is this your legal name? ☐ Yes ☑ No

Gender* Female

Patient Mailing Address

SSN

City | Zip | **Country/State** Michigan

Main Phone*

Second Phone

Cell

Cell

Email*

Former name

If patient is Minor-Patient/Legal Guardian Name

Primary care Physician Name

Primary care Physician Phone Number

HEALTH PERCEPTION & HEALTH MANAGEMENT PATTERN

What procedure are you having performed?

Side of body? Left

Date of Surgery* 08/30/2036

Physician* Jon Hain, MD

Your height: ft in | Weight: lbs Kg | BMI:

PEDIATRIC: ☐ Full Term ☐ Premature

Number of weeks at birth:

Is Immunization Current? ☐ Yes ☐ No

If no, explain

Have you had recent illnesses? (Cough, cold, fever)	☐ Yes ☐ No	
Exposure to contagious diseases in last two weeks? (Chicken Pox, TB, MRSA)	☐ Yes ☐ No	
Have you been hospitalized in a nursing home or hospital in the past 60 days?	☐ Yes ☐ No	

ANESTHESIA SCREENING

Have you had any adverse reaction to anesthesia?	☐ **Yes** ☐ **No**	
Have any blood relatives had an adverse reaction to anesthesia?	☐ Yes ☐ No	
Have you been diagnosed with Obstructive Sleep Apnea?	☐ Yes ☐ No	
Do you use a CPAP Machine?	☐ Yes ☐ No	
Do you snore loudly?	☐ Yes ☐ No	
Have you been told that you stop breathing while sleeping?	☐ Yes ☐ No	
Do you fall asleep easily while reading, watching TV or riding in a car?	☐ Yes ☐ No	

OXYGENATION & CIRCULATION

Do you use Tobacco?

_____ _____ cigarette a day For _____ years

Do you drink Alcohol? ☐ Yes ☐ No _____ per day or _____ per week

Do you use recreational drugs (Marijuana, Cocaine?) ☐ Yes ☐ No _____

Heart or Circulation Problems? ☐ **Yes** ☐ **No**

☐ Heart Disease ☐ Stents ☐ Murmur
☐ Previous heart attack ☐ Chest pain ☐ Blood disorders

_____

☐ Peripheral vascular disease ☐ Irregular heart beat ☐ Anemia
☐ Heart Surgery ☐ High blood pressure ☐ Lowplatelets
☐ Pacemaker / Heart Defibrillator ☐ Mitral Valve Prolapse ☐ High Cholesterol

Cardiologist Name _____ Cardiologist Phone Number _____

Why are you seeing a cardiologist? Any additional information?

Lung or Breathing problems? ☐ **Yes** ☐ **No**

☐ Emphysema (Chronic Obstructive Pulmonary Disease) ☐ Asthma
☐ Breathless after flight of stairs ☐ Home Oxygen

_____

☐ Chronic Cough or Bronchitis

Other:

History of CANCER (for youtself)? ☐ **Yes** ☐ **No** _____

NUTRITION METABOLIC PATTERN

Are you Diabetic? ☐ **Yes** ☐ **No**

Do you control your diabetes with: ☐ oral medication ☐ insulin ☐ diet controlled
☐ Glucose monitoring at home

_____ _____

☐ Thyroid disease ☐ Hypothyroid ☐ Hyperthyroid

Gastrointestinal problems? ☐ **Yes** ☐ **No**

☐ Heartburn - Acid Reflux Disease ☐ Ulcers ☐ Gastroparesis
☐ Hiatal Hernia

REPRODUCTIVE PATTERN

Have you had a period in the last year? ☐ Yes ☑ No If so, when? _____

Have you had a tubal ligation? ☐ Yes ☑ No If so, when? _____

Have you had a hysterectomy? ☐ Yes ☑ No

Are you pregnant? ☐ **Yes** ☑ **No** Breast feeding ☐ Yes ☑ No

KIDNEY PROBLEMS

Bladder or Kidney or Bowel problems? ☐ **Yes** ☐ **No**

☐ Enlarged prostate (BPH) ☐ Stones
☐ Urinary Incontinence ☐ Dialysis ☐ Renal failure

COGNITIVE PERCEPTION

Do you have or had any of the following? ☐ **Yes** ☐ **No**

☐ Stroke	☐ Memory loss/Alzheimer's	☐ Migraines
☐ Mini-strokes (TIA)	☐ Seizures	☐ Depression
☐ Fainting Spells	☐ Balance / Dizziness	☐ Anxiety

Other problems

PRIOR SURGERIES

Did you have prior surgeries or procedures? ☐ None

Provide Details about Surgery or Procedures

Any other health concerns that we need to know?

COMMUNICATION

Can you speak English? ☐ **Yes** ☐ **No** What is your preferred language? _____

Howdo you communicate? ☐ Normal Speech ☐ Sign Language ☐ Lip Reading ☐ Gestures ☐ Writing ☐ Other

PAIN PERCEPTION

Do you have pain? ☐ Yes ☐ No

Pain location: _____ When did it start? _____

Rate your current pain (0 to 10): _____ What relieves it? _____

Provide details:

Howmuch pain do you expect to have at the time of discharge on a scale of 0 to 10? _____

FALL ASSESSMENT

Do you need assistance with walking, standing or sitting? ☐ **Yes** ☐ **No**

Do you use? ☐ Cane ☐ Walker ☐ Wheelchair

Do you have? ☐ Arthritis ☐ Joint pain ☐ Back problems ☐ Paralysis

COMMUNICABLE DISEASES

Do you have any of the following? ☐ **Yes** ☐ **No**

☐ HIV or AIDS ☐ Tuberculosis ☐ Wound / Skin Infections ☐ Hepatitis

VALUES - BELIEFS

Do you have any special customs or religious beliefs that would help us in caring for you? ☐ Yes ☐ No

If yes, describe

EDUCATION NEEDS

Did you have any pre-procedure teaching? Doctor's office If Other: _____ Did you receive our brochure? Yes

Do you or your family need information on the following?

☐ Current surgery ☐ Activity after surgery ☐ Home care ☐ Other

DISCHARGE PLANNING

Who will be driving you home?

Name: _____ **Main Contact Phone:** **Cell** _____

Relationship: _____ Secondary Phone: Cell _____

ADDITIONAL INFO

May we give instructions related to your care with the person noted above? ☐ **Yes** ☐ **No**

☐ **I have read and understand the Patient Rights and Notices. (View)**

MEDICATION SUMMARY LIST

☐ I don't take any medications

List belowall scheduled and as needed medications. Include prescribed over-the-counter, herbal medications, inhalers, eye drops, ointments, etc.

Current Medications

Medication Name	Dosage	Route	When	How many times?	Last taken

Medications Added Day of Surgery:

New Medications Added	Dosage	Route	How often taken	Prescribing Doctor	Pharmacy Contacted
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Medications on Hold	Dosage	Route	How often taken	Prescribing Doctor	

☐ RN explained the importance of maintaining an updated list of current medications that may be given to a health care provider

☐ You may resume all your current medications

☐ New Medications reviewed at discharge

☐ Medications to hold reviewed at discharge

Discharge Nursing Signature Date Time

Patient Representative Signature Date Time

ALLERGIES / INTOLERANCES

Do you have allergies to medications? ☐ **Yes** ☐ **No**

Type of Medication	Reaction	Any Additional Reaction?

Are you Allergic to Latex? ☐ **Yes** ☐ **No**

Allergic to Iodine? ☐ **Yes** ☐ **No**

Any significant Environmental or Food allergies? ☐ Yes ☐ No

If yes please explain here...

Preoperative Health Assessment Reviewed by

PAT Nurse Signature Date Time

Admission Nurse Signature Date Time