



HIGHLAND HOSPITAL
AMBULATORY PROCEDURE CENTER
PREADMISSION
HEALTH SURVEY

HH 10605APC MR

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Outpatient

RR DONNELLEY

Phone Number: 341-6877 • Fax Number: 341-8453

Patient Name: _____ Date: _____

Daytime Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Male Female

Physician: _____ Surgery Date: _____

Type of Procedure: _____

Family Physician: _____ Phone Number: _____ Date of Last Visit: _____

Pharmacy: _____ Phone Number: _____

May we have your permission to leave a voicemail/message at your home?..... Yes No

May we leave a message with other household members?..... Yes No

Have you been a patient at Highland before, and if so, when? _____

ANESTHESIA HISTORY:

Do you have a reaction to anesthesia? Yes No

If yes, describe type of reaction: _____

Does someone in your family have a reaction to anesthesia? Yes No If yes, relation: _____

If yes, describe type of reaction: _____

Other seasonal/environmental allergies: _____

MEDICAL HISTORY: Please check (✓) if any conditions below have been a problem and circle the condition.

<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
	Dementia/Alzheimer's Disease		Diabetes / Insulin Pump
	Epilepsy / Seizure		Arthritis / Gout / Osteoporosis
	Migraine Headaches		Urine Problems / Infection
	Glaucoma / Cataracts		Kidney Disease / Kidney Stones
	Thyroid Problems		Dialysis: When: _____ Where: _____
	Lupus/Fibromyalgia		Difficulty Swallowing
	Asthma / COPD		Gall Bladder Disease / Pancreatitis
	Pneumonia / Recent Cold		Stomach Problems / Ulcers / Heartburn / GERD
	Shortness of Breath / Chronic Cough		Liver Disease / Hepatitis
	Sleep Apnea / CPAP		Bowel Problems / Colitis / Diarrhea / Crohn's / IBS / Polyps
	Pulmonary Embolus		Nervous Breakdown / Depression / Psychiatric Care
	Elevated Cholesterol		Skin Condition / Psoriasis
	Heart Attack / Chest Pain / Irregular Heart Beat		Broken Bones / Joint Problems
	Rheumatic Fever / Heart Murmur		Polio / Multiple Sclerosis / Parkinsons / Rheumatoid Arthritis
	Pacemaker / Defibrillator		Cancer - What Kind: _____
	High Blood Pressure / Stroke / TIA		TB or Positive Testing
	Blood Clots in Legs / Varicose Veins		Alcohol / Drug Abuse
	Anemia/ Bleeding Problems		AIDS/HIV+

SURGICAL HISTORY: None

Year	Surgery	Anesthesia	Year	Surgery	Anesthesia

PAIN ASSESSMENT: Yes NO

Are you having pain? New Chronic Is this pain: dull intermittent constant sharp

Location of pain: _____

Pain level (0=no pain, 10=worst pain): _____

What causes pain? _____ What relieves pain? _____

HISTORY

	YES	NO
Is there anyone at home or work that is hurting you?		
Have you ever had a blood transfusion? When _____ Any reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you had an EKG in the last 5 years? If yes, bring a copy for comparison.		
	YES	NO
Do you currently have, or have you had an infection in the past week? What _____		
Have you or any blood relatives had any unusual reactions to anesthesia? (other than Nausea and Vomiting)		
I have used <input type="checkbox"/> CIGARETTES <input type="checkbox"/> PIPE <input type="checkbox"/> CIGAR <input type="checkbox"/> CHEW <input type="checkbox"/> Never		
<input type="checkbox"/> I smoke _____ packs a day for _____ years.		
<input type="checkbox"/> I quit smoking _____ years ago. I used to smoke _____ packs a day for _____ years.		
I have used the following: <input type="checkbox"/> None		
<input type="checkbox"/> Alcohol: I drink (how many) _____ drinks per _____		
<input type="checkbox"/> Recreational/Street drugs: types - _____		
I use these every _____ days/weeks/months.		
Date of last use: _____		

When was the last time you had liquids to drink? _____

When was the last time you had solid food? _____

Reason for procedure: _____

If the test you are having requires taking a bowel prep, please note medications taken.

Fleets Phosphsoda: 1 1/2 oz twice _____ pm _____ pm _____ am

Fleets Phosphsoda: 1 oz three times _____ pm _____ pm _____ pm

Ducolax Tablets # _____

Simethicone Tablets # 80 mg _____ 125 mg _____

Golytely: one gallon _____ Time: _____ Nulytely: 4 liters _____ Time: _____

Half Lytely _____ MOVI Prep _____

Miralax: _____

Magnesium Citrate: one bottle _____

How much did you actually drink? _____ Other: _____

Did you have any problems with prep? ___ If so, What? _____

Please list any questions you have: _____

Do you have help after discharge? _____

Check all that apply

- Full Dentures Loose Teeth Crutches
- Top Bottom Hearing Aid Walker
- Partial Dentures Eyeglasses Wheelchair
- Top Bottom Contact Lenses Cane
- Body Piercing Prosthesis
- All body piercing must be removed

FOR WOMEN ONLY

How many times have you been pregnant? _____

How many times have you given birth? _____

When was your last menstrual period? ____/____/____
(mm/dd/yy)

Menopause Yes No

Menses amount: Scant Moderate Heavy

What year was your last pap smear? _____
 Normal Abnormal

What year was your last mammogram? _____

Do you know how to examine your breasts? Yes No

FOR MEN ONLY

What year was your last rectal/prostate exam? _____

Do you know how to do a self-testicular exam? Yes No

Reviewed by: _____

DISCHARGE PLANNING SCREEN

Your occupation: _____

Education Background grade school high school
 college other

Do you require an interpreter? Yes No

Do you live: Alone Family Friends Facility

Do you live in a: House Townhouse Apartment
 Other _____

Are there steps in your house: Yes No

If Yes, how many? _____ Elevation: _____

Do you receive help at home now? Please specify: _____

Who will be driving you home from the hospital?

Name: _____

Home Phone # _____ Work Phone # _____

RN signature: _____