

BRING THIS TO YOUR PREADMISSION TESTING APPOINTMENT



HIGHLAND HOSPITAL

Patient Identification Sticker

Fax Number: 341-8377

PREADMISSION HEALTH SURVEY

Name: _____ Date of Surgery: _____ Surgeon: _____

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

Family Physician: _____ Phone number: _____

Pharmacy used: _____ Phone number: _____

PLEASE LIST ALL MEDICATIONS CURRENTLY TAKING INCLUDING INSULIN, HERBS, INHALERS, VITAMINS, ASPIRIN, OR OXYGEN: NONE

DRUG NAME	DOSAGE	TIME	DRUG NAME	DOSAGE	TIME
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

LIST ANY ALLERGIES OR REACTIONS TO ANY MEDICATIONS, FOOD, AND/OR LATEX: NONE

LIST ALL OPERATIONS YOU HAVE HAD: _____

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

<input checked="" type="checkbox"/>	Epilepsy and/or Seizure	<input checked="" type="checkbox"/>	Thyroid Problems
	Head Injury or Loss of Consciousness		Urine Problems and/or Infection
	Migraine Headaches		Kidney Disease and/or Kidney Stones
	Glaucoma and/or Cataracts		Gall Bladder Disease and/or Pancreatitis
	Asthma / COPD		Stomach Problems and/or Ulcers / Recent Vomiting
	Pneumonia / Recent Cold		Bowel Problems and/or Colitis / Recent Diarrhea
	Shortness of Breath / Chronic Cough		Enlarged Prostate
	Elevated Cholesterol		Nervous Breakdown and/or Depression and/or Psychiatric Care
	Collapsed Lung		Skin Condition and/or Psoriasis
	Heart Attack / Chest Pain / Irregular Heart Beat		Broken Bones and/or Joint Problems
	Rheumatic Fever and/or Heart Murmur		Polio
	Pacemaker / Defibrillator Checked: _____		Cancer - What Kind:
	High Blood Pressure and/or Stroke and/or TIA		TB or Positive Testing
	Blood Clots in Legs and/or Varicose Veins		Alcohol and/or Drug Abuse
	Anemia and/or Bleeding Problems		AIDS or HIV+
	Diabetes		Liver Disease and/or Hepatitis
	Arthritis and/or Gout		Any Childbirth Complications

ARE YOU HAVING ANY PAIN - IF YES, WHERE: _____

LIST ANY ADDITIONAL MEDICAL PROBLEMS: _____

IF YOU RECEIVE DIALYSIS, WHEN? _____, and WHERE? _____

DO YOU HAVE VASCULAR ACCESS? _____

List any other hospital admissions not mentioned on the front:

	YES	NO		YES	NO
Is there anyone at home or work that is hurting you?			Do you currently have, or have you had an infection recently?		
Have you ever had a blood transfusion? When _____ Any reaction?			Have you or any blood relatives had any unusual reactions to anesthesia? (other than Nausea and Vomiting)		
Have you had an EKG in the last 5 years? If yes, bring a copy for comparison.			Do you smoke or have you ever smoked? Packs per day _____ Number of years _____ When did you quit? _____		
Unintentional (>5#) Change in body weight in past 12 Months: If yes, <input type="checkbox"/> Gained _____ (Amt) In _____ (Time) <input type="checkbox"/> Lost _____ (Amt) In _____ (Time)			Do you drink alcohol? _____ daily _____ occasionally Amount: _____		
Recent (Last 30 Days) Decrease in Appetite: Rate Appetite As: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			Do you use any social drugs? (cocaine, pot)		
Diet Restrictions: (Eg. Diabetic, Sodium, Renal, etc...) If yes, Explain _____					
Nutritional Supplements / Support / Herbal Supplements: If yes, Explain _____					
Chewing or Swallowing Problems:					

Check all that apply

- _____ Full Dentures _____ Top _____ Bottom
- _____ Partial Dentures _____ Top _____ Bottom
- _____ Loose Teeth _____ Crutches
- _____ Hearing Aid _____ Walker
- _____ Eyeglasses _____ Wheelchair
- _____ Contact Lenses _____ Prosthesis

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) _____ / _____ / _____
- 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 _____ Friends
_____ Family _____ Facility
- Do you live in a: _____ House _____ Apt
_____ Townhouse _____ Other
- Are there steps in your house: _____ Yes _____ No
- If Yes, how many? _____ Elevation: _____
- Do you receive help at home now? Please specify:

- Are you responsible for the care of another person or persons? _____ Yes _____ No
- If Yes, do you need someone to care for this individual during your hospitalization? _____ Yes _____ No
- Who will be driving you home from the hospital?
Name: _____
- Home Phone # _____ Work Phone # _____
- Who will be assisting you at home following your hospitalization with the following:
• dressing/bathing • medication administration (eye drops/injections)
• meals • transportation/shopping
- Name: _____
- Home Phone # _____ Work Phone # _____
- R.N. signature _____