HIGHLAND
HOSPITAL

HEALTH CARE SURVEY

HH 11042 MR

PLEASE DO NOT WRITE IN GRAY AREAS

PLEASE ANSWER THE FOLLOWING QUESTIONS	STAFF USE ONLY
I have the following: ☐ Loose teeth; broken teeth ☐ Caps, crowns ☐ None ☐ Dentures ☐ left hearing aid ☐ Glasses/contacts ☐ right hearing aid	
☐ I do not speak or understand English. The language I speak is _________ ☐ I do speak English ☐ I am hearing impaired ☐ I am visually impaired	☐ Social Service notified that an interpreter is needed on DOS: Date: __________
I have used: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing tobacco ☐ Never ☐ I smoke ___ packs a day for ___ years. ☐ I quit smoking ___ years ago. I used to smoke ___ packs a day for ___ years.	
I have used the following: ☐ None ☐ Alcohol I drink (how many) ___ drinks per ____ ☐ Recreational/Street Drugs: Type: __________ I use them every ___ day/weeks/months. Date of last use: ________	
I have the following **RESPIRATORY** illnesses: ☐ None ☐ Cold or respiratory illness in the last month ☐ Chronic obstructive pulmonary disease (emphysema, chronic bronchitis) ☐ Pulmonary Embolus ☐ Pneumonia: treated on: ______ ☐ Asthma ☐ Tuberculosis: treated on: __________ ☐ Sleep Apnea ☐ I use a CPAP/BIPAP at home ☐ Are you a snorer, have you been told you gasp or hold breath while sleeping ☐ Do you feel groggy/tired/sleepy even after hours of adequate sleep ☐ I use home oxygen @___ liters/min ☐ Other: __________	☐ Pt instructed to bring CPAP/BIPAP on DOS.
I have the following **HEART** illnesses: ☐ None ☐ High blood pressure for ___ years. ☐ High Cholesterol ☐ Arrhythmia, irregular heart beat, or palpitations ☐ these make me dizzy or lose consciousness ☐ Chest pain, heaviness, pressure or tightness ☐ Angina ☐ It's duration and/or intensity has recently changed ☐ Heart Attack(s) Date(s): __________ ☐ Congestive Heart Failure ☐ Coronary Angioplasty or stent ☐ Heart Valve Disease or murmur ☐ Mitral Valve Prolapse ☐ Other valve disease: __________ ☐ Pacemaker ☐ Automatic Implantable cardioverter defibrillator (AICD) ☐ I have seen a cardiologist or had cardiac testing: __________ Name of cardiologist: __________ ☐ Other: __________ ☐ This blood relative of mine has a cardiac history: __________ Describe: __________	☐ Anesthesia Alert made for ☐ Pacemaker/AICD ☐ Other: ________ on: Date: ______ Pacemaker/AICD Last date checked ______
PHYSICAL ACTIVITIES: ☐ No limitations ☐ I have trouble breathing or get chest pain when I: ☐ climb one flight of stairs ☐ do heavy work around the house like scrubbing floors ☐ Other: __________ ☐ I regularly participate in physical exercise/activities	
I have had the following **GASTOINTESTINAL** problems: ☐ None ☐ Heart burn or Acid Reflux (GERD-Gastroesophageal Reflux Disease) ☐ Stomach or duodenal ulcers. ☐ Bowel Problems ☐ Gall Stones ☐ Hepatitis B or C ☐ Liver failure ☐ Ostomy Type: ______ ☐ Other: __________	

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I have had the following **BLEEDING** problems: ☐ None ☐ Frequent nose bleeds or large bruises. ☐ Blood clots ☐ Von Willebrands Disease ☐ Anemia ☐ Hemophilia ☐ family with bleeding disorders ☐ Other: __________ ☐ Varicose Veins	
I have had **KIDNEY** diseases: ☐ None ☐ Kidney Failure or abnormal kidney function ☐ I use peritoneal dialysis ☐ I use hemodialysis on the following days: __________ At this dialysis center: __________ ☐ Stones ☐ Prostate Problems ☐ Other: __________	
I have had the following **JOINT** problems: ☐ None ☐ Arthritis: ☐ Osteo (Degenerative) Where: __________ ☐ Rheumatoid ☐ Previous joint replacement: Where: __________ ☐ Other: __________	
I have had **ENDOCRINE** disorders: ☐ Thyroid ☐ None ☐ Diabetes: ☐ diet controlled ☐ Oral meds only ☐ Insulin dependent ☐ Type I DM ☐ Type II DM ☐ Unknown ☐ I have an insulin pump ☐ Other: __________	☐ Pt. given protocol on insulin pump, teaching was accomplished and understood
I have had **NERVE OR MUSCLE** illnesses: ☐ None ☐ Stroke ☐ TIA (Transient Ischemic Attack) ☐ The above gave me weakness Where: __________ ☐ Migraines ☐ Multiple Sclerosis ☐ Myasthenia Gravis ☐ Malignant Hyperthermia ☐ Muscular Dystrophy ☐ Seizures/Epilepsy ☐ Lupus ☐ Fibromyalgia ☐ Other: __________	
I have had **PSYCHIATRIC** disorders such as: ☐ None ☐ Depression ☐ Anxiety ☐ Other: __________	
☐ I have had previous **BREAST CANCER** surgery and I can not have blood draws, I.V.'s or blood pressures on my: ☐ right ☐ left arm.	☐ Lymphedema Alert
There is a chance I may be pregnant: ☐ Yes ☐ No ☐ Maybe Date of last menstrual period: __________	
I have any of the following conditions: ☐ None ☐ Cancer: site __________ ☐ Alzheimers ☐ Dementia ☐ HIV/AIDS ☐ Other infection __________	
I have the following diet restrictions: ☐ None ☐ Diabetic ☐ low sodium ☐ renal ☐ Other: __________ ☐ I use nutritional supplements ☐ I have no restrictions ☐ My appetite is: ☐ Good ☐ Fair ☐ Poor ☐ I have difficulty swallowing/chewing ☐ I have had an unintentional weight gain or loss of more than 5 pounds in the past 12 months. If yes: ☐ gained ___ pounds in ____ (wk/month) ☐ lost ___ pounds in ____ (wk/month)	

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BLOOD TRANSFUSION HISTORY: ☐ I have never had a transfusion ☐ I have had a transfusion ☐ I have had a transfusion within the last 3 months ☐ I have had a reaction to a transfusion. Type: __________	
DISCHARGE PLANNING: • Do you live: ☐ Alone ☐ Family ☐ Friends ☐ Facility • Do you live in a: ☐ House ☐ Townhouse ☐ Apartment ☐ Facility ☐ Other: __________ • Are there steps in your home? ☐ Yes ☐ No How many? _____ • Do you receive help at home now? ☐ Yes ☐ No If yes, please specify: __________ • Are you responsible for the care of another person or persons? ☐ Yes ☐ No If yes, do you have someone to care for this person while you are in the hospital? ☐ Yes ☐ No • Who will drive you home from the hospital? Name: __________ Phone: __________ Alternate Phone number: __________ • After discharge who will assist you with the following: dressing, bathing, medication administration, meals, transportation? • ☐ Same as above **or** ☐ Name: __________ Phone: __________ Alternate Phone number: __________	☐ Social Work notified that discharge planning will be needed. Date: __________ ☐ For short stay or day of surgery admissions, discharge planning section documented on Admission Risk Assessment form (15777)

SURGICAL HISTORY:

TYPE OF SURGERY	DATE & HOSPITAL	TYPE OF SURGERY	DATE & HOSPITAL

HEALTH HISTORY REVIEWED BY:

Date/Time: ________ **Name and title:** ________________ **Initials:** _____
Date/Time: ________ **Name and title:** ________________ **Initials:** _____
Date/Time: ________ **Name and title:** ________________ **Initials:** _____
Date/Time: ________ **Name and title:** ________________ **Initials:** _____
Date/Time: ________ **Name and title:** ________________ **Initials:** _____

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RR DONNELLEY

HPI:

Vital Signs: BP ______ HR ______ HT ______ cm WT ______ kg BMI ______

EYES: ☐ PERRL ☐ EOMI ☐ Nystagmus

MOUTH/OROPHARYNX: ☐ Normal ☐ Abnormal Mouth opening: ☐ Full ☐ Restricted

TEETH: ☐ Normal ☐ Dentures: ☐ Partial -- ☐ Upper ☐ Lower
☐ Teeth missing ☐ Full -- ☐ Upper ☐ Lower
☐ Bridges(s) ☐ Crown(s) ☐ Poor Hygiene/Repair

NECK: AROM: ☐ Full ☐ Restricted -- ☐ Flexion ☐ Extension ☐ Rotation
☐ Palpable lymph nodes: ☐ Anterior ☐ Posterior
☐ Carotid bruits: ☐ Right ☐ Left

LUNGS:

	Right	Left	Bilateral
☐ Clear			
☐ Decreased breath sounds	☐	☐	☐
☐ Wheezes	☐	☐	☐
☐ Rales	☐	☐	☐
☐ Rhonchi	☐	☐	☐

HEART: ☐ Normal – RRR, S1 S2, ☐ Rubs ☐ Gallops ☐ Murmur: Grade: ____
Rhythm ☐ Regular ☐ Irregular

EXTREMITIES: Upper: ☐ Normal ☐ Edema -- ☐ Right ☐ Left
Lower: ☐ Normal ☐ Right ☐ Left
Pulses: Radial: ☐ Normal ☐ Diminished ☐ Absent
Post Tib: ☐ Normal ☐ Diminished ☐ Absent

NEUROLOGIC: ☐ Alert/Oriented x3 ☐ Speech Clear ☐ Gait Steady ☐ Cranial Nerves 3-12 intact

☐ **ANESTHESIA ALERT SENT:** ______________________

IMPRESSION:

____

PLAN:

____

MD/NP/PA ______________________ **DATE/TIME:** ______________

SURGEON ______________________ **DATE/TIME:** ______________

Key: PERRL: Pupil equal round react to light AROM: Active range of motion
EOMI: Extra occular movement intact

Rev 7/10

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☐ Inpatient
☐ Outpatient
☐ ED

Patient Name: ______________________

Medical Record #: ______________________

DO NOT USE ABBREVIATIONS: U, IU, Q.D., Q.O.D., Trailing zero (X.0 mg), Lack of leading zero (.X mg), MS, MSO_4, $MgSO_4$, µg, T.I.W., A.S., A.D., A.U.

Document Date and Time of Each Note.

DATE	TIME	AM PM	

Rev 5/10

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RR DONNELLEY

Planned Surgery: ______________________
Pharmacy: ______________ Phone number: ______________
Primary Care Physician ______________ Phone number: ______________ Date of last visit: ________
Have you been a patient at Highland Hospital before? ☐ Yes ☐ No

ANESTHESIA HISTORY: Have you been told you have a "difficult airway?" ☐ Yes ☐ No
Do you or any of your blood relatives have a reaction to anesthesia? ☐ Yes ☐ No If you answered "yes", please describe: ______________________ ☐ Self Relative: __________

***ALLERGIES: If more room is needed, please attach a separate sheet**

Allergies: drugs/food	List reactions/side effects
None ☐	
Latex/Rubber Products (bananas, kiwi, avocado, chestnut) ☐ None **Staff only:** ☐ Entered into ESI ☐ Form completed	
Iodine (Contrast dye, shellfish)/ Other None ☐	

MEDICATION LIST: PLEASE DO NOT WRITE IN GRAY AREAS
☐ I take no medications. ☐ Unable to obtain medication history. Reason: ______________
Information source: ☐ Patient ☐ Family ☐ Wallet Card ☐ med. Bottles ☐ Other: ______________
PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (Including prescriptions, Over-The-Counter, herbals, patches, inhalers, eye drops, supplements, vitamins, aspirin and oxygen). If more room is needed, please attach a separate sheet.

DRUG NAME	DOSE	HOW OFTEN	LAST DOSE *COMPLETED BY NURSE ON DAY OF SURGERY INITIALS: ______*	DISCHARGE OUTPATIENT ONLY *COMPLETED BY PROVIDER*
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______
				C DC N R ______

KEY: C-Continue DC-Discontinue N-New R-Resume on this date

FOR ONE DAY SURGERY PATIENTS ONLY:
Signature of NP/PA/Physician reconciling meds at discharge ______________________

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