Patient Name: _____

Date of surgery/procedure: _____

Patient Label

Patient History Intake Form

1. What is the phone number we can reach you at the evening before your surgery/procedure?

   _____

   Is it ok to leave a message for you on your phone? Yes No

2. Who is completing this form? _____

3. Who will bring you to the hospital? _____

4. Who is your emergency contact?
   Name and phone number: _____

5. Please list the name and phone number of the person who will take you home when you are discharged. _____
   Will this person help to care for you when you get home? Yes No
   If no, list name and phone number of who will help care for you.

   _____

ALLERGIES: _____

6. For females of childbearing age (12-55) ☐ N/A

Are you pregnant?

- ☐ Possible unconfirmed
- ☐ Negative confirmed
- ☐ Positive confirmed
  Due date _____
- ☐ Hysterectomy
- ☐ Not started menstruation
- ☐ First day of your last menstrual period _____ ☐ Unknown
- ☐ Are you currently breastfeeding? Yes No
- ☐ Premenopausal
- ☐ Postmenopausal
- ☐ Unable to obtain
- ☐ Gave birth during this visit
- ☐ Other _____

7. How tall are you? _____

8. Please list any health problems you have or have had in the past. Please explain any "Yes" responses.

Yes	No	
☐	☐	Heart (B/P, arrhythmia, History of Heart Surgery) _____
☐	☐	Lung (CF; Asthma) _____
☐	☐	Eyes/Ears/Nose/Throat _____
☐	☐	Have you been told you snore loudly?
☐	☐	Is your neck larger than 17 inches?
☐	☐	Do you often feel tired and sleepy during the day?
☐	☐	Diabetes _____
☐	☐	Thyroid/Endocrine disease _____
☐	☐	Liver problems/Hepatitis _____
☐	☐	Frequent heartburn _____
☐	☐	Intestine/Stomach (Chrons, IBS, GERD) _____
☐	☐	Kidney/Bladder/Incontinence _____
☐	☐	Anemia _____
☐	☐	Bleeding/Clotting Disorder _____
☐	☐	Autoimmune disease (rheumatoid arthritis, sarcoidosis, lupus, etc.) _____
☐	☐	Infections (HIV, Lyme disease, MRSA, TB, etc.) Please List: _____

_____

These are screening questions for Sleep Apnea, also called "Obstructive Sleep Apnea" or "OSA."

Patient Name: _____

Date of surgery/procedure: _____

Patient Label

Health problems (continued) Please explain any "Yes" responses.

Yes No

☐ ☐ Skin _____

☐ ☐ Bone/Joint/Muscle (arthritis, osteoporosis, back pain, fibromyalgia) _____

_____

☐ ☐ Neurological (ADD, MS, MD, CP, Alzheimer's, Parkinson's, migraines, numbness, etc.) _____

_____

☐ ☐ Cancer _____

☐ ☐ Psychiatric (depression, anxiety, bipolar, PTSD, schizophrenia) _____

_____

☐ ☐ Have you ever been told you are allergic to latex (balloons, gloves, condoms — not adhesives) or reacted to latex products?If yes, list your allergic symptoms. _____

☐ ☐ Have you had anesthesia/sedation in the past? _____

9. Please list all surgeries/procedures and dates.

_____

_____

_____

_____

_____

10. Please list any family medical history (blood relative) that we need to be aware of to provide your care during this admission.

_____

_____

_____

11. Have you or any blood relative had any of the following reactions to anesthesia?

☐ Yes ☐ No

	Self	Blood Relative	Comments
High temperature caused by anesthesia			
Slow to regain muscle movement (Pseudocholinesterase Deficiency)			
Severe nausea and/or vomiting after anesthesia			
Told it was difficult to place the breathing tube in your airway			
Prolonged confusion after anesthesia			
Significant change in blood pressure			
Motion sickness			

Yes No

☐ ☐ Are you willing to receive blood/ blood products in an emergency?

☐ ☐ Have you or someone else donated blood to be given to you during this admission? ☐ Myself ☐ Someone else

☐ ☐ Have you received a blood transfusion in the past?

☐ ☐ If yes, have you had a transfusion reaction? If yes, please describe in detail _____

_____

Patient Name: _____

Date of surgery/procedure: _____

Patient Label

12. Do you or have you ever used any of the following? ☐ Yes ☐ No

	What kind? How much?	How often?
Tobacco products		
Alcohol		
Alternative medical treatments (acupuncture, herbal therapy, etc.)		
Recreational drugs		

13. What is the patient's preferred language? _____

What is the caregiver's preferred language? _____

14. List any other language you or your caregiver are comfortable speaking. _____

15. Do you need an interpreter? ☐ Yes ☐ No

16. Please check all that you presently have/use:

- ☐ Glasses
- ☐ Contacts
- ☐ BiPAP/CPAP
- ☐ Removable Dental Pieces (Dentures)
- ☐ Walker/Cane/Crutches/Wheelchair
- ☐ Removable prosthesis
- ☐ Oxygen at home
- ☐ Hearing Aid Right/Left/Both
- ☐ Pacemaker and/or Defibrillator

If yes, name of physician who cares for you and your device

_____

17. Do you have any dietary restrictions? ☐ Yes _____ ☐ No

18. Do you have any cultural, ethnic or religious beliefs that need to be included in your care or education while in the hospital?

☐ Yes (describe) _____ ☐ No

19. While in the hospital, how will you learn best about your surgery/procedure?

	Doing	Reading	Hearing	Watching	Comment
Patient					
Caretaker/family					

20. Do you have any barriers to learning? ☐ Yes ☐ No Hearing Language Visual Anxiety Literacy

21. Does your caregiver have any barriers to learning? ☐ Yes ☐ No Hearing Language Visual Anxiety Literacy

22. Have you enacted any of the following?

Directive to Physicians ☐ Yes ☐ No

Medical Power of Attorney ☐ Yes ☐ No If Yes, MPOA name, Phone number _____

Declaration for Mental Health Treatment ☐ Yes ☐ No

Organ/Tissue Donation ☐ Yes ☐ No

If you have enacted any of the above, please bring them to the hospital the day of your surgery/procedure.

23. Screening: Do you have:

Night sweats? ☐ Yes ☐ No

Bloody, persistent cough? ☐ Yes ☐ No

Fever/chills? ☐ Yes ☐ No

24. Have you traveled outside of the country in the last three months? ☐ Yes ☐ No

If so, where? _____