

BRING THIS TO YOUR PREADMISSION TESTING APPOINTMENT

STRONG HEALTH
HIGHLAND HOSPITAL

**PREADMISSION
HEALTH SURVEY
HH 10605 MR**
Page 1 of 2

Inpatient
 Outpatient

Phone Number: 341-6707 • Fax Number: 341-8377

Patient Name: _____ Date: _____

Daytime Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Male Female

Surgeon: _____ Surgery Date: _____

Type of Surgery: _____

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.

✓	✓
Dementia/Alzheimer's Disease	Diabetes / Insulin Pump
Epilepsy / Seizure	Arthritis / Gout / Osteoporosis
Head Injury / Loss of Consciousness	Urine Problems / Infection
Migraine Headaches	Kidney Disease / Kidney Stones
Glaucoma / Cataracts	Dialysis: When: _____ Where: _____
Thyroid Problems	Enlarged Prostate
Lupus/Fibromyalgia	Gall Bladder Disease / Pancreatitis
Asthma / COPD	Stomach Problems / Ulcers / Heartburn
Pneumonia / Recent Cold	Liver Disease / Hepatitis
Shortness of Breath / Chronic Cough	Bowel Problems / Colitis / Diarrhea / Crohn's
Sleep Apnea / C-PAP	Nervous Breakdown / Depression / Psychiatric Care
Collapsed Lung / Pulmonary Embolus	Skin Condition / Psoriasis
Elevated Cholesterol	Broken Bones / Joint Problems
Heart Attack / Chest Pain / Irregular Heart Beat	Polio / Multiple Sclerosis / Parkinsons
Rheumatic Fever / Heart Murmur	Cancer - What Kind: _____
Pacemaker / Defibrillator Checked _____	TB or Positive Testing
High Blood Pressure / Stroke / TIA	Alcohol / Drug Abuse
Blood Clots in Legs / Varicose Veins	AIDS HIV+
Anemia / Bleeding Problems	Any Childbirth Complications

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? _____

PSYCHOSOCIAL HISTORY

	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 in the past week? What _____		
Have you ever had a blood transfusion? When _____ Any reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No			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.			Have you ever used tobacco products? If Yes, what type: <input type="checkbox"/> cigarettes ___ # of packs per day ___ # of years <input type="checkbox"/> cigars ___ # per day ___ # of years <input type="checkbox"/> chewing tobacco _____ per day ___ # of years		
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? <input type="checkbox"/> daily <input type="checkbox"/> occasionally Amount: _____ Type: _____		
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/street drugs? (cocaine, pot) Amount: _____ How often: _____		
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

- | | | |
|---|--|---|
| <input type="checkbox"/> Full Dentures
<input type="checkbox"/> Top <input type="checkbox"/> Bottom | <input type="checkbox"/> Loose Teeth
<input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Crutches
<input type="checkbox"/> Walker |
| <input type="checkbox"/> Partial Dentures
<input type="checkbox"/> Top <input type="checkbox"/> Bottom | <input type="checkbox"/> Eyeglasses
<input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Wheelchair
<input type="checkbox"/> Cane
<input type="checkbox"/> 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

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: _____

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 (if different than above):

- dressing/bathing
- medication administration (eye drops/injections)
- meals
- transportation/shopping

Name: _____

Home Phone # _____ Work Phone # _____

RN signature _____

Reviewed by: _____