

PATIENT HISTORY

Information Obtained From: Patient Parent Spouse Other: _____ History Updated: _____
 Primary Language Spoken: English Other: _____
 Translator Name: _____ Family Member Staff Language Line Other: _____
 Procedure as stated by patient: _____ Ht. _____ Wt. _____ Stated
 Factor affecting patient needs: None Religious/Cultural Practices Speech Language Barrier Vision
 Hearing Special Family Concerns: _____
 Who will drive you home? _____ Telephone Number: _____

Patient/Family History	Patient or family history of ANESTHESIA COMPLICATIONS: <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, DESCRIBE:	
	Patient or family history of MALIGNANT HYPERTHERMIA: <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, DESCRIBE:	
Alcohol Consumption Tobacco Use	Amount: _____ <input type="checkbox"/> Daily <input type="checkbox"/> Weekly #Yrs. _____	DENTURES	<input type="checkbox"/> UPPER <input type="checkbox"/> OTHER <input type="checkbox"/> CAPS/CROWNS
	Smoke: _____ <input type="checkbox"/> PPD <input type="checkbox"/> Chew #Yrs. _____	PARTIALS	<input type="checkbox"/> UPPER <input type="checkbox"/> OTHER <input type="checkbox"/> BRIDGES
Recreational Drugs	Quit: _____ <input type="checkbox"/> Number of years _____ <input type="checkbox"/>		
	Smoking Cessation Brochure Given: _____ <input type="checkbox"/>	<input type="checkbox"/> LOOSE TEETH <input type="checkbox"/> HEARING AID - Left <input type="checkbox"/> Right <input type="checkbox"/> <input type="checkbox"/> GLASSES <input type="checkbox"/> PROSTHESIS <input type="checkbox"/> JEWELRY REMOVED <input type="checkbox"/> CONTACT LENSES	

Advance Directives? Yes No
 Power of Attorney Needed? Yes No Copy on Chart

Patient Teaching: 1) Pre-admit instructions for specific surgical procedure(s) NPO @ _____
 2) Pre-Op: Preparations for specific surgical procedure(s), anesthesia and post-op hospital care explained
 3) Pain: Post-op pain expectations. Pain management modalities. Pain scale appropriate to patient needs. Given () pain brochure
 Date: _____ Time: _____ RN Signature _____
 Above teaching given to: _____ via literature() and or Individual Instructions ()
 Patient / family member was () Receptive () Uncooperative () Denies Needs

YEAR AND DATE OF PAST SURGICAL PROCEDURES / HOSPITAL ADMISSIONS:

IMPLANTED DEVICES: _____

CARDIOVASCULAR: <input type="checkbox"/> N/A <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Blockage <input type="checkbox"/> Stent(s) <input type="checkbox"/> Angioplasty <input type="checkbox"/> CABG <input type="checkbox"/> Heart Attack <input type="checkbox"/> Angina <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Rate <input type="checkbox"/> Pacemaker <input type="checkbox"/> Internal Defibrillator <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Mitral Valve Prolapsed <input type="checkbox"/> Valve Disease <input type="checkbox"/> Aortic Aneurysm <input type="checkbox"/> Peripheral Arterial Disease <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Triglycerides <input type="checkbox"/> Other: _____	RESPIRATORY: <input type="checkbox"/> N/A <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sleep Apnea Uses: <input type="checkbox"/> C-PAP <input type="checkbox"/> Bi-PAP <input type="checkbox"/> Oxygen at _____ Liters Used when: _____ <input type="checkbox"/> Other: _____ TRANSPLANT: <input type="checkbox"/> N/A Date of Transplant: _____ <input type="checkbox"/> Organ: _____ <input type="checkbox"/> Tissue: _____ <input type="checkbox"/> Other: _____ Date: _____ Time: _____
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