OUR LADY OF THE LAKE SURGICAL HOSPITAL

PRE-ADMISSION Patient Information

Patient Label

❑ Cell
❑ Home

Patient's Name: _____ **Best phone # to reach:** _____

Procedure/Operation Scheduled: _____ **Date Scheduled:** _____

Chief Complaint: _____

Occupation: _____

Living arrangements (with whom): _____

Family support (who): _____

Do you wear Glasses? ❑ Yes ❑ No **Contacts?** ❑ Yes ❑ No **Do you wear Dentures?** ❑ Yes ❑ No
Removable bridges? ❑ Yes ❑ No **Do you use Hearing aides?** ❑ Yes ❑ No

Height: _____ **Weight:** _____

Have you had fever recently? ❑ Yes ❑ No

Have you had any recent acute infections? ❑ Yes ❑ No If yes, please explain: _____

_____

Have you ever had STAPH Infection? ❑ Yes ❑ No
Do you have any skin problems? ❑ Yes ❑ No

If yes, please explain: _____

Drug/Medication **Allergies** & Reaction: _____

_____

_____

Food Allergies: _____

Preferred Pharmacy: _____ **Pharmacy Phone #** _____

Are you on any special diet? ❑ Yes ❑ No If yes, please explain: _____

_____

Are your Immunizations up to date? ❑ Yes ❑ No

Date of last Flu vaccination _____ Pneumonia vaccination_____

Have you ever had any of the following communicable diseases? (check all that apply):

❑ Chicken pox ❑ Shingles ❑ Measles ❑ Mumps ❑ Rubella (German measles)
❑ Tetanus ❑ Pertussis (Whooping cough) ❑ Hepatitis

Do you currently have any complaints of pain? ❑ Yes ❑ No Location: Pain Level:_____ (0-10)

If yes, please describe and give location: _____

Any recent labs/blood work ❑ Y ❑ N **If yes, Where?** _____

EKG (heart tracing) within last 6 months ❑ Y ❑ No **If yes, where?** _____

Chest X-ray within last 12 months ❑ Y ❑ No **If yes, where?** _____

Please Write NONE if you have never had any complications from:

Anesthesia Reactions or Complications (yours): _____

_____

Anesthesia Reactions or Complications (in your family): _____

_____

Body Systems (1-9) - Please check NONE if you have had no issues.

1. Neurological (Brain, Nervous System): *Have you ever been **medically treated** or **hospitalized** for any of the following? (**check** all that apply)*

❑ CVA/Stroke ❑ TIA ❑ Dementia/Alzheimer's ❑ Parkinson's ❑ Seizures/Epilepsy ❑ Spinal Cord Injury
❑ Head Trauma ❑ Brain Injury ❑ Headaches ❑ Numbness ❑ Weakness ❑ **NONE**

Additional details on any of the above if checked: _____

_____

Any other Neurological Disorders not listed above: _____

_____

Family history of stroke? ❑ Y ❑ N If yes, who? ❑ father ❑ mother ❑ brother ❑ sister

2. Cardiac (Heart): *Have you ever been **medically treated** or **hospitalized** for any of the following? (**check** all that apply)*

❑ Pacemaker ❑ Internal Defibrillator ❑ Blood Thinners ❑ Heart murmur
❑ Recent Echocardiogram ❑ Heart Attack ❑ Angina/Chest pain ❑ Peripheral Vascular Disease (PVD)
❑ Coronary Artery Disease ❑ Aneurysm ❑ Blood Clots ❑ Palpitations
❑ Congestive Heart Failure (CHF) ❑ Rheumatic Fever ❑ High Cholesterol ❑ **NONE**
❑ Irregular Heart Beat ❑ High Blood Pressure ❑ Low Blood Pressure

Additional details on any of the above if checked: _____

_____

Any other Cardiac Disorders not listed above: _____

_____

Family history of High Blood Pressure? ❑ Y ❑ N If yes, who? ❑ father ❑ mother ❑ brother ❑ sister

3. Respiratory (Lungs, Breathing): *Have you ever been **medically treated** or **hospitalized** before for any of the following? (**check** all that apply)*

❑ Never Smoked ❑ Current smoker: how many packs per day? _____ how long?_____yrs Do you want to quit? ❑ Yes ❑ No
❑ Former Smoker: quit when?_____

❑ COPD/Emphysema ❑ Asthma ❑ Smoke Exposure ❑ Tobacco use
❑ Lung Disease ❑ Tuberculosis (TB) ❑ Bronchitis ❑ Pneumonia
❑ Oxygen use ❑ Inhaler use ❑ Pulmonary Embolism ❑ Shortness of Breath
❑ Sleep apnea ❑ Recent cough ❑ Breathing treatments ❑ Bipap use for sleep apnea
❑ Productive cough ❑ **NONE**

Additional details on any of the above if checked: _____

_____

Any other Respiratory Disorders not listed above: _____

_____

Family history of asthma? ❑ Y ❑ N If yes, who? ❑ father ❑ mother ❑ brother ❑ sister

4. Gastrointestinal (GI- Abdomen, Stomach) *Have you ever been **medically treated** or **hospitalized** for any of the following? (**check** all that apply)*

❑ Liver problems ❑ Ulcers ❑ Heartburn ❑ Hiatal Hernia ❑ Nausea
❑ Vomiting ❑ Reflux ❑ Diarrhea ❑ Constipation ❑ Abdominal Pain
❑ Bowel problems ❑ Colostomy / Ileostomy ❑ Hemorrhoids ❑ Celiac disease ❑ Pancreatitis
❑ Bleeding from GI tract ❑ Changes in weight ❑ **NONE**

Additional details on any of the above if checked: _____

_____

Any other Gastrointestinal Disorders not listed above: _____

_____

5. Genitourinary (GU- Bladder, Kidneys): *Have you ever been **medically treated** or **hospitalized** for any of the following? (**check** all that apply)*

❑ Kidney Disease ❑ Kidney stones ❑ Urinary tract Infection ❑ Dialysis ❑ Bladder problems
❑ Incontinence ❑ Urination problems ❑ Prostate Problems ❑ Hernias ❑ **NONE**

Additional details on any of the above if checked: _____

_____

Any other Genitourinary Disorders not listed above: _____

_____

6. Reproductive: *Have you ever been **medically treated** or **hospitalized** for any of the following? (**check** all that apply)*

❑ Birth Control Pills (BCP) ❑ Hysterectomy ❑ Pelvic Inflammatory Disease ❑ Endometriosis ❑ Fibroids
❑ Tubal Ligation ❑ Sexually Transmitted Disease (STD)

Any history of reproductive disorder? ❑ Yes ❑ No _____

If yes, please describe: _____

Date of last menstrual period for females:_____ Age of menopause_____

Can you get pregnant? ❑ Yes ❑ No

7. Musculoskeletal (Muscles, Bones): *Have you ever been **medically treated** or **hospitalized** for any of the following? (**check** all that apply)*

❑ Arthritis ❑ Rheumatoid Arthritis ❑ Osteoporosis ❑ Gout ❑ Fractures (broken bones)
❑ Amputation ❑ Fibromyalgia ❑ Muscle disorders ❑ Musculoskeletal trauma/deformity
❑ Back pain ❑ Neck pain ❑ Any history of falls ❑ **NONE**

Are you able to perform personal activities of daily living? ❑ Independent ❑ Partially Dependent *(need some help)* ❑ Totally Dependent *(need total assistance)*

Additional details on any of the above if checked: _____

_____

Any other Musculoskeletal Disorders not listed above: _____

_____

Present use of ❑ Cane ❑ Walker ❑ Crutches ❑ Wheelchair ❑ Scooter

8. Ear, Eye, Nose and Throat (EENT): *Have you ever been **medically treated** or **hospitalized** for any of the following? (**check** all that apply)*

❑ Cataracts ❑ Glaucoma ❑ Eye problems ❑ Eye infections/injury
❑ Ear infections/injury ❑ Sinus problems ❑ Difficulty swallowing ❑ Oral bleeding
❑ Dental problems ❑ Sore throat at present ❑ **NONE**

Additional details on any of the above if checked: _____

_____

Any other Disorders not listed above: _____

_____

9. Endocrine: *Have you ever been **medically treated** or **hospitalized** for any of the following? (**check** all that apply)*

❑ Steroid therapy ❑ Hormone therapy ❑ Diabetes ❑ Hypoglycemia ❑ Thyroid disease
❑ Hormone disorders ❑ Lupus ❑ Autoimmune disease ❑ **NONE**

Additional details on any of the above if checked: _____

_____

Any other Disorders not listed above: _____

_____

Family history of Diabetes? ❑ Y ❑ N ❑ Type 1 ❑ Type 2 If yes, who? ❑ father ❑ mother ❑ brother ❑ sister

10. Blood Disorders/Cancer History: *Have you ever been **medically treated** or **hospitalized** for any of the following? (**check** all that apply)*

❑ Blood transfusion (if yes, give date and any reaction)_____ _____
❑ Cancer ❑ Anemia ❑ Leukemia ❑ HIV/Aids ❑ Hemophilia
❑ Sickle Cell ❑ Chemotherapy ❑ Radiation ❑ Unexplained bleeding ❑ **NONE**

Additional details on any of the above if checked: _____

_____

Any other Blood Disorders not listed above:_____

_____

11. Psychiatric/Social: *Have you ever been **medically treated** or **hospitalized** for any of the following? (**check** all that apply)*

❑ Depression ❑ Anxiety ❑ Psychiatric Problems ❑ Alcohol use ❑ Substance/Drug use
❑ Caffeine use ❑ Family problems ❑ Job loss ❑ Sleep difficulties ❑ Recent stress or loss
❑ **NONE**

Additional details on any of the above if checked: _____

_____

Any other Disorders not listed above: _____

_____

Previous Hospitalizations (other than for surgeries):

_____

_____

_____

Previous Surgeries: *(List dates if possible)*: _____

_____

_____

_____

12. VTE: Our Lady of the Lake Surgical Hospital Screening Patients who may be at risk for a Blood Clot

Please complete to the best of your knowledge.
Place a check on the correct response.

VTE Risk Assessment				
Have you ever had blood clot in legs or lungs?	○ Yes	○ No		
Family history of blood clots in the veins?	○ Yes	○ No		
Do you have leg swelling every day?	○ Yes	○ No		
Do you have visible varicose veins?	○ Yes	○ No		
Do you have Inflammatory Bowel Disease?	○ Yes	○ No		
Do you have Emphysema or COPD?	○ Yes	○ No		
>3 days bed rest due to injury/illness in past month?	○ Yes	○ No		
Have you had pelvic fx or plaster leg cast in last month?	○ Yes	○ No		
Have you had a heart attack or heart failure?	○ Yes	○ No		
have you had major surgery lasting >1 hr in last month?	○ Yes	○ No		
Do you or have you had cancer?	○ Yes	○ No		
Do you use Birth Control or Estrogen replacement therapy?	○ Yes	○ No		
Current Age Group	○ Under 40	○ 40-59	○ 60-69	○ Over 70
Are you pregnant or had a baby in the last month?	○ Yes	○ No		
Joint replacement, broken hip/pelvis/femur in last month?	○ Yes	○ No		