**USF Health Endoscopy and Surgery Center Pre-Admission Health History Intake**

Date: ____________________________

Name: ______________________________________ Phone #: (___)___________________

Relationship to Patient: ________________________ Pt. Name ________________________

I am Legal Guardian/Power of Attorney and I have documentation.

Day Phone #: (___)___________________ Evening Phone #: (___)_________________

Ht: _________ Wt: __________ Sex: M F Date of Birth: ___________________

Surgeon Name: _______________________ Procedure Time: _______________

Description of Procedure: ______________________________________________________

Emergency Contact: ____________________ Phone #: (___)_________________________

Person Driving Home After Procedure ________________________________________

Person Caring for Patient After Procedure ________________________________________

| ***Have you had:*** | | | | |
|---|---|---|---|---|
| EKG? | Yes | No | Location: | Date: |
| X-rays? | Yes | No | Location: | Date: |
| Lab Tests? | Yes | No | Location: | Date: |
| Other Prep? | Yes | No | Location: | Date: |
| ***Allergies*** | ***Yes*** | ***No*** | ***If No, Skip to next Section*** | |
| Food? | Yes | No | Describe: | |
| Drugs | Yes | No | Describe: | |
| Latex/Rubber? | Yes | No | Describe: | |
| Other Allergies? | Yes | No | Describe: | |
| Other Reactions? | Yes | No | Describe: | |
| ***Diabetes History*** | | | | |
| Diabetes? | Yes | No | Describe: | |
| Hypoglycemia? | Yes | No | Describe: | |
| Diet Controlled? | Yes | No | Describe: | |
| Med Controlled? | Yes | No | Describe: | |
| ***Anesthesia History*** | | | | |
| Unusual Reaction? | Yes | No | Describe: | |
| Family? | Yes | No | Describe: | |
| ***Surgical History: Need Additional Room Check Here Use Back of Sheet*** | | | | |
| Procedure: | | | Date: | |
| Procedure: | | | Date: | |
| Procedure: | | | Date: | |
| Procedure: | | | Date: | |
| Procedure: | | | Date: | |
| Procedure: | | | Date: | |
| Procedure: | | | Date: | |
| Procedure: | | | Date: | |
| Procedure: | | | Date: | |
| Do You Have Implants? | Yes | No | | |
| Type: | | | | |
| Type: | | | | |

| ***Medications – Includes Prescribed, Over-the-Counter, Herbals, Steroids, Diet Pills*** | | |
|---|---|---|
| Medication Name | Dosage/Strength | Frequency |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |
| 11. | | |

| ***General System Questions*** | | | |
|---|---|---|---|
| ***Impairments – Do you have:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Hearing Impairments? | | | |
| Vision Impairments?<br>Glasses/Contacts | | | |
| Mobility Impairments? | | | |
| Artificial Limbs? | | | |
| Other Impairments/Disabilities? | | | |
| ***Dental – Do you have:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Dentures | | | |
| Bridges? | | | |
| Crowns or Caps? | | | |
| Chipped or Loose Teeth? | | | |
| ***Skin – Do you have:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Burns? | | | |
| Rashes? | | | |
| Bruises? | | | |
| Other Skin Conditions? | | | |
| Skin that Tears Easily? | | | |
| ***Neurological – Do you have or had:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Stroke or TIA? | | | |
| Seizures? | | | |
| Paralysis? | | | |
| Alzheimer’s? | | | |
| Parkinson’s | | | |
| Other Neurological Conditions? | | | |
| ***Musculoskeletal – Do you have/had:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Neck, Back, or Jaw Problems? | | | |
| Joint Replacement? | | | |
| Muscular Dystrophy? | | | |
| Arthritis? | | | |
| Other Musculoskeletal Conditions? | | | |

| ***Blood Disorders – Do you have/had:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
|---|---|---|---|
| Blood Transfusion? | | | |
| Blood Clots? | | | |
| Sickle Cell Disease? | | | |
| Anemia? | | | |
| Bruise Easily? | | | |
| Family History of Hemophilia? | | | |
| ***Liver – Do you have/had:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Jaundice? | | | |
| Cirrhosis? | | | |
| Hepatitis? (List Type) | | | |
| ***Thyroid – Do you have/had:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Hypothyroidism | | | |
| Hyperthyroidism | | | |
| Other Thyroid Conditions | | | |
| ***Kidney – Do you have/had:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Burning with Urination? | | | Frequency: |
| Bleeding with Urination? | | | |
| On Dialysis? | | | |
| Have any Urinary Problems | | | |
| ***Stomach – Do you have/had:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Ulcers or Hiatal Hernia? | | | |
| Acid Reflux Disease? | | | |
| Gallbladder Conditions? | | | |
| Chronic Distention | | | |
| GI/Rectal Bleeding? | | | |
| ***Psychiatric – Do you have/had:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Treated for Depression? | | | |
| Anxiety or Panic Disorder? | | | |
| Substance Abuse? | | | |
| Developmental Delays? | | | |
| Other Psychiatric Disorders? | | | |
| ***Pulmonary – Do you have/had:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Asthma? | | | |
| Restrictive Airway Disease? | | | |
| Bronchitis? | | | |
| COPD? | | | |
| Sleep Apnea? | | | |
| Exposed to TB? | | | |
| Use Nebulizer or Breathing Machine? | | | |
| Shortness of Breath? | | | |
| Smoke or Use Tobacco? | | | Packs per Day: |
| Using Home Oxygen? | | | |
| Cold in the past 2 weeks? | | | |
| Other Pulmonary Conditions? | | | |

| ***Cardiovascular – Do you have/had:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
|---|---|---|---|
| Angina/Chest Pain? | | | |
| High/Low Blood Pressure? | | | |
| Rheumatic Fever? | | | |
| Mitral Valve Prolapse? | | | |
| Heart Surgery/Stent/Catheter? | | | |
| Heart Attack? | | | |
| Palpitations or Irregular Heart Beat? | | | |
| Pacemaker or Defibrillator? | | | |
| ***Pain – Do you have/had:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Chronic Pain? | | | Location? Duration: |
| Pain Assoc. with Being Here Today? | | | |
| 0 = No Pain | | | |
| 1-2 = Hurts a Little Bit | | | |
| 3-4 = Hurts a little More | | | |
| 5-6 = Hurts Even More | | | |
| 7-8 = Hurts a Whole Lot | | | |
| 9-10 = Hurts the Worst | | | |
| ***Other – Do you:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Drink Alcohol? | | | |
| Use Recreational Drugs? | | | |
| Have Body Piercings? | | | |
| Have Contagious Diseases? | | | |
| Speak Another Language? | | | Language Spoken: |
| Need an Interpreter? | | | |
| Have any Spiritual/Cultural Needs? | | | |
| ***Women and Minors:*** | ***Yes*** | ***No*** | ***Comments/Explanation:*** |
| Date of Last Menstrual Period? | N/A | N/A | |
| Are you Pregnant? | | | |
| Are Child's Immunizations Current? | | | |
| Any Special Needs/Concerns? | | | Explain: |

Patient Signature ______________________________ Date ____________________

Guardian Signature ____________________________ Date ____________________

Nurse Signature: ______________________________ Date ____________________