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? 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 _____