

ASSESSMENT DATE:	TIME:	PROCEDURE:	OR DATE:	OR TIME:
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Information Obtained from: Pt. Resp. Party On-line In person Telephone Fax

Patient/Responsible Party Education Assessment:

Education Level: _____

Barriers to Learning: _____

Education Needs: _____

Readiness to Learn: Receptive Other

Primary Language: English Other: _____

Communication Barrier: Non-English Aphasic Deaf Blind

< 2 years of age

Interpreter Needed: Family Member Significant Other

Hospital arranged through:

PREVIOUS HOSPITALIZATIONS/SURGICAL PROCEDURES

Recent exposure to infections/contagious diseases: No Yes What? _____

History of blood transfusion: No Yes Reaction? _____

Could you be pregnant? No Yes Date of LMP: _____

MEDICAL HISTORY

<p>Cardiologist Name: <input type="checkbox"/> None</p> <p>Phone # _____</p> <p><input type="checkbox"/> Chest pain</p> <p>Last episode _____</p> <p>Treatment _____</p> <p>Date of last EKG _____</p> <p>Past stress test _____</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Heart Attack: Date _____</p> <p><input type="checkbox"/> Irreg. Heart Rate</p> <p>Last episode _____</p> <p>Treatment _____</p> <p>Rhythm if known _____</p> <p><input type="checkbox"/> Murmur</p> <p><input type="checkbox"/> MVP</p> <p><input type="checkbox"/> Pacemaker/AICD</p> <p>Co. Name & Number: _____</p> <p><input type="checkbox"/> Pacer Card <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Instructed to bring</p> <p><input type="checkbox"/> Elevated Cholesterol</p> <p><input type="checkbox"/> High Blood Pressure</p>	<p>Respiratory Problems <input type="checkbox"/> None</p> <p><input type="checkbox"/> Asthma OR Reactive airway</p> <p><input type="checkbox"/> Childhood Only</p> <p><input type="checkbox"/> Exercise Induced</p> <p><input type="checkbox"/> Seasonal</p> <p>Inhaler <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Will bring</p> <p><input type="checkbox"/> COPD – O2 <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> TB</p> <p><input type="checkbox"/> Sleep Apnea Mach. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Instructed to bring</p> <p>Tobacco <input type="checkbox"/> None</p> <p><input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigar</p> <p><input type="checkbox"/> Chew <input type="checkbox"/> Pipe</p> <p>Amount: _____</p> <p>Quit Date: _____</p> <p>Colon Disease <input type="checkbox"/> None</p> <p><input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> Diverticulitis</p> <p>GI Problems <input type="checkbox"/> None</p> <p><input type="checkbox"/> GERD/Reflux</p> <p><input type="checkbox"/> Ulcer</p> <p><input type="checkbox"/> Hiatal Hernia</p>	<p>Liver Problems <input type="checkbox"/> None</p> <p><input type="checkbox"/> Hepatitis A B C</p> <p>Urinary/Kidney Disorders <input type="checkbox"/> None</p> <p><input type="checkbox"/> UTI</p> <p><input type="checkbox"/> Stones</p> <p><input type="checkbox"/> Difficulty urinating</p> <p><input type="checkbox"/> Enlarged prostate</p> <p><input type="checkbox"/> Incontinence -stress</p> <p>Back/Neck Injuries <input type="checkbox"/> None</p> <p><input type="checkbox"/> Disc disease</p> <p><input type="checkbox"/> Numbness/Tingling</p> <p><input type="checkbox"/> Spinabifida</p> <p><input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> Polio</p> <p>Location: _____</p> <p>Seizure <input type="checkbox"/> None</p> <p>Last Episode: _____</p> <p><input type="checkbox"/> TIA/Stroke Last Episode: _____</p> <p><input type="checkbox"/> Neurologist Name: _____</p> <p>Phone # _____</p> <p>Diabetes <input type="checkbox"/> None</p> <p><input type="checkbox"/> Type 1</p> <p><input type="checkbox"/> Type 2</p> <p><input type="checkbox"/> Hypoglycemia</p>	<p>Skin Disorders <input type="checkbox"/> None</p> <p><input type="checkbox"/> Intact</p> <p><input type="checkbox"/> Irritation/Rashes</p> <p><input type="checkbox"/> Breakdown</p> <p><input type="checkbox"/> Open wounds</p> <p>Bleeding disorders <input type="checkbox"/> None</p> <p><input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> Von Willebrands</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Thyroid Disease</p> <p>Mental Disorders <input type="checkbox"/> None</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Panic Attack</p> <p>Alcohol use <input type="checkbox"/> None</p> <p><input type="checkbox"/> Beer Amt: _____</p> <p><input type="checkbox"/> Wine Amt: _____</p> <p><input type="checkbox"/> Mixed Amt: _____</p> <p><input type="checkbox"/> Recreational drug use</p> <p><input type="checkbox"/> Other: _____</p>
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Problems with Anesthesia: None Best Contact # for Anes. Provider: _____

High Temperature: <input type="checkbox"/> Patient <input type="checkbox"/> Family	Family History: <input type="checkbox"/> None <input type="checkbox"/> Heart Problems <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Bleeding Disease <input type="checkbox"/> Other:
Allergic Reaction: <input type="checkbox"/> Patient <input type="checkbox"/> Family	
Delayed Awakening: <input type="checkbox"/> Patient <input type="checkbox"/> Family	

Functional Status Assessment

Excellent (>7 METs) Jogging (10minute mile) Scrubbing floors Singles tennis

Moderate (4 to 7 METs) Cycling Climbing a flight of stairs Golf(without cart) Walking 4 mph Yardwork Treadmill Wii Fitness

Poor (<4Mets) Vacuuming Activities of daily living (e.g. eating, dressing, bathing) Walking 2 mph Writing

Other: _____ **Chest Pain** Yes No **Shortness of Breathe** Yes No

Are there any special family concerns, safety issues personally/environmentally, emotional expectations, religious or cultural practices that need to be followed during this hospitalization? Yes No

I have fully reviewed this questionnaire and answered all questions truthfully and to the best of my knowledge. I am aware that my answers can affect my health care, or that of the patient for whom I am responsible and my family or significant other accepts responsibility for any belongings/valuables.

Patient Signature: _____ Date: _____ Reviewed by: _____ RN

Vital Signs: Stated Actual Ht _____ Wt _____ T: _____ R: _____ BMI: _____ P _____ BP _____ Pulse OX _____

The section below is to be completed by Anesthesiologist

ANESTHESIA/PRE-OP	ANESTHESIA ASSESSMENT: Problem with Anesthesia: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> History & Physical Reviewed
	Pertinent LAB/EKG/CXR: _____
	Pertinent Physical Findings: _____
	Airway Class: 1 2 3 NPO since: _____
	Problems: _____
	ASA Class: I II III IV E Plan: MAC GA REG SAB EPID. <input type="checkbox"/> Discussed Plan with Patient <input type="checkbox"/> Discussed Plan with Patient Parent
	Pre Med: _____
	Anesthesia Provider: _____ Date: _____

BAYLOR MEDICAL CENTER AT FRISCO
Patient History/Anesthesia Assessment