newport
Center for Special Surgery

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Pre-Admission Medical History

Name:_____

FOR OFFICE USE: (we will fill in)

Patient Number:_____
Date of Admission:____/____/____
Reviewed by:

1. TIME OF DAY:_____AM/PM

2. WHILE I AM HERE, PLEASE CALL ME:_____

3. AGE:_____years **HEIGHT**_____ **WEIGHT**_____ **BMI**_____

WHY YOU ARE HERE TODAY:

4. I AM GOING TO HAVE SURGERY ON MY:

	LEFT	RIGHT		LEFT	RIGHT		LEFT	RIGHT
breast	☐	☐	ankle	☐	☐	head		
neck	☐	☐	foot	☐	☐	face		
low back	☐	☐	toes	☐	☐	eye	☐	☐
shoulder	☐	☐	heart			ear	☐	☐
arm	☐	☐	lungs	☐	☐	nose		
elbow	☐	☐	thyroid	☐	☐	throat		
wrist	☐	☐	breast	☐	☐	tongue		
hand	☐	☐	stomach			hysterectomy		
fingers	☐	☐	bowel			female organs	☐	☐
hip	☐	☐	rectum			prostate		
thigh	☐	☐	spleen			bladder		
knee	☐	☐				kidney	☐	☐
leg/calf	☐	☐	gall bladder			other _____		

5. MY SURGEON IS:_____

6. DO YOU HAVE A FAMILY DOCTOR? ☐Yes ☐No

Doctor's name:_____
Address:_____
City:_____ State:_____ Zip:_____
Telephone: (___) ___-____
I wish the Doctor (would / would not) be informed of my admission.

7. WHOM SHOULD WE CONTACT IN CASE OF EMERGENCY?

Name:_____
Relationship:_____
Daytime phone #: (_____) _____-_____
Home phone #: (_____) _____-_____
Address:_____
_____

Name:_____
Relationship:_____
Daytime phone #: (_____) _____-_____
Home phone #: (_____) _____-_____
Address:_____
_____

8. ALLERGIES:

☐ NONE ☐ Penicillin ☐ Codeine ☐ Sulfa ☐Hay Fever
☐ Other_____

9. PLEASE LIST EACH ONE OF YOUR ALLERGIES, ONE AT A TIME:

Allergic to:_____
Allergic reaction:_____
Means of control:
Nothing ☐
I avoid:_____
Means of treatment:_____
Is treated with what medicine:_____
Allergy shots: ☐Yes ☐No
Type:_____
Treated by Doctor:_____
Address:_____
Telephone #: (___) _____-_____

Allergic to:_____
Allergic reaction:_____
Means of control:
Nothing ☐
I avoid:_____
Means of treatment:_____
Is treated with what medicine:_____
Allergy shots: ☐Yes ☐No
Type:_____
Treated by Doctor:_____
Address:_____
Telephone #: (___) _____-_____

MEDICATIONS:

10. MEDICINES TAKEN IN THE PAST SIX (6) MONTHS:

Daily aspirin or anti-inflammatory	☐ YES	☐ NO
Cortisone shots or pills	☐ YES	☐ NO
High blood pressure pills	☐ YES	☐ NO
Water pills	☐ YES	☐ NO
Heart medicine	☐ YES	☐ NO
Insulin	☐ YES	☐ NO
Anti-depressants (MAO inhibitor)	☐ YES	☐ NO
Antibiotics	☐ YES	☐ NO
Herbs	☐ YES	☐ NO
Blood thinner	☐ YES	☐ NO
Tetanus immunization	☐ YES	☐ NO

Tetanus immunization date: _____/_____/_____

11. MEDICATIONS/HERBS/VITAMINS BEING TAKEN NOW:

MEDICATION	FORM (tabs/cap/shot)	DOSAGE (if known)	TIMES PER DAY

12. MEDICINES/HERBS THAT YOU HAVE STOPPED TAKING IN THE LAST MONTH:

Medicine	Why did you stop?

13. HAVE YOU EVER RECEIVED ANY BLOOD TRANSFUSIONS? ☐ YES ☐ NO

DATE:_____/_____/_____ REACTION: ☐ YES ☐ NO
DATE:_____/_____/_____ REACTION: ☐ YES ☐ NO
DATE:_____/_____/_____ REACTION: ☐ YES ☐ NO

14. HAVE YOU GIVEN YOUR BLOOD FOR THIS OPERATION? ☐ YES ☐ NO

Where:_____

PREVIOUS SURGERIES:

15. LIST ALL THE SURGERIES YOU HAVE HAD:

Procedure:_____
Date: ____/____/____
What Hospital/Surgicenter:_____
Outcome: _____

Procedure:_____
Date: ____/____/____
What Hospital/Surgicenter:_____
Outcome: _____

Procedure:_____
Date: ____/____/____
What Hospital/Surgicenter:_____
Outcome: _____

Procedure:_____
Date: ____/____/____
What Hospital/Surgicenter:_____
Outcome: _____

16. DESCRIBE ANY COMPLICATIONS WITH ANY SURGERY OR ANESTHESIA:

_____
_____
_____

PREVIOUS HOSPITALIZATIONS:

17. LIST THE TIMES YOU HAVE BEEN IN ANY HOSPITAL OVERNIGHT OTHER THAN FOR SURGERY:

Reason:_____
Where:_____
How did you do:_____

Reason:_____
Where:_____
How did you do:_____

FAMILY HISTORY:

18. HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD DIFFICULTY WITH SURGERY OR ANESTHESIA?

☐ Nausea/vomiting	☐ Heart problem	☐ Breathing problem
☐ Headache	☐ High body temperature	☐ Low blood pressure
☐ Bleeding	☐ Blood clots	☐ Death

☐ Other:_____

REVIEW OF SYSTEMS: (Please circle all that apply to you)

19. HEAD PROBLEMS: ☐ YES ☐ NO

unexplained hair loss
increased head size
headaches
migraines
other:_____

20. NECK PROBLEMS: ☐ YES ☐ NO

stiff
thyroid trouble
pain
other:_____

21. SKIN PROBLEMS: ☐ YES ☐ NO

infections
pimples
psoriasis
warts
cold sores
skin lesions
skin cancers: where/what_____
dermatitis
shingles
other:_____

22. EYE PROBLEMS: ☐ YES ☐ NO

loss or change in vision
pain
dryness
excessive watering
double vision
glasses
contacts
cataracts
glaucoma
other:_____

23. EARS/HEARING PROBLEMS: ☐ YES ☐ NO

loss of hearing
hearing aid
ringing or buzzing
infection
tubes
other:_____

24. NOSE/THROAT PROBLEMS: ☐ YES ☐ NO

hoarseness
change in voice
nose bleeds
post-nasal drip
blocked nasal passages
sinus infection
trouble swallowing
chronic infections/sore throat
other:_____

25. RESPIRATORY PROBLEMS: ☐ YES ☐ NO

asthma
wheezing
shortness of breath
pain with breathing
much sputum
sleep apnea
emphysema
bronchitis
tuberculosis (T.B.)
pneumonia
recent cold
history of smoking
How much do you smoke?_____
other:_____

26. CARDIOVASCULAR PROBLEMS: ☐ YES ☐ NO

chest pain/angina
irregular or fast heartbeat
low blood pressure
high blood pressure
heart disease
leg cramps at night
leg cramps while walking
cold fingers or toes
sweating fingers or toes
leg or ankle swelling
heart attack
history of rheumatic fever
heart murmur
circulation problem
persistent bleeding/bruising
blood disorder
blood transfusion
stroke
other:_____

27. GASTROINTESTINAL PROBLEMS: ☐ YES ☐ NO

stomach ulcer
nausea/vomiting
lack of appetite
stomach pain
heartburn
change in bowel habits
constipation
diarrhea
hemorrhoids
gall bladder trouble
pancreatitis
colitis
jaundice or hepatitis
bloody stool
hiatal hernia
recent weight loss/gain
other:_____

28. GENITOURINARY PROBLEMS: ☐ YES ☐ NO

leakage
bloody urine
strong urine
frequent urination
night time urination
trouble starting/stopping/both
pain with urination
back pain
sores on genitalia
infection
discharge
herpes
AIDS
AIDS related complex
kidney/bladder problem
kidney stone
bladder tumor
other:_____

29. NEUROLOGIC PROBLEMS: ☐ YES ☐ NO

headaches
fainting
seizures - Epilepsy
stroke
paralysis of limbs
numbness/tingling
blackouts
severe head injury
other:_____

30. EMOTIONAL PROBLEMS: ☐ YES ☐ NO

nervous breakdown
feel blue
frequent crying
anxious
tension
stress prone
cannot sleep
exhausted
drug abuse
alcohol abuse
other:_____

31. BLEEDING DISORDER PROBLEMS: □ YES □ NO
anemia other:_____
bleeding problem

32. METABOLIC PROBLEMS: □ YES □ NO
diabetes other:_____
hypoglycemia

33. MUSCULOSKELETAL PROBLEMS: □ YES □ NO
joint pain/arthritis limited movement
back/neck pain other:_____

34. OTHER PROBLEMS: □ YES □ NO
cancer dentures/bridgework/braces
addiction history _____

35. GENETIC/INHERITED DISORDERS:

_____
_____
_____

36. FEMALE MEDICAL HISTORY:
Pregnant Now: □ YES □ NO □ MAYBE due date___/___/___
Birth Control Pills: □ YES □ NO type_____ stopped__/__/__
Last Menstrual Period date___/___/___ nature_____
Term Pregnancies most recent___/___/___ total number_____
Miscarriages most recent___/___/___ total number_____
Pregnancy Terminations most recent___/___/___ total number_____
Endometriosis Problem most recent___/___/___ total number_____
Menopause date___/___/___ nature_____
IUD name_____ reason_____

37. GYNECOLOGICAL PROBLEMS:

_____
_____

38. HAVE YOU HAD HIV OR AIDS TESTING? □ YES □ NO

39. ARE YOU FOLLOWING A SPECIAL DIET? □ YES □ NO
Describe:_____
_____

40. WHAT IS YOUR ALCOHOL INTAKE? □ NONE

AMOUNT		PERIOD OF TIME
less than 1		day
1 or 2		week
3 to 6	PER	month
more than 6		year

last use:_____

41. WHAT IS YOUR MARIJUANA INTAKE? □ NONE

□ SMOKE □ VAPE □ FOOD

AMOUNT		PERIOD OF TIME
less than 1		day
1 or 2		week
3 to 6	PER	month
more than 6		year

last use:_____

Comments:_____

42. SLEEP APNEA ASSESSMENT

S	Do you **Snore** loudly (loud enough to be heard through closed doors)?	Yes	No
T	Do you often feel **Tired**, fatigued, or sleepy during the daytime?		
O	Has anyone **Observed** you to stop breathing during your sleep?		
P	Do you have or are you being treated for high blood **Pressure**?		
B	**BMI** >35kg/m		
A	**Age** > 50 years old		
N	**Neck** Circumference > 40 cm (size 16 neck)		
G	**Male** Gender		
TOTAL	If yes to 5 or more you have a high probability of obstructive sleep apnea		
	Do you have a CPAP Machine?		

VALUABLES:

43. LIST ALL THE VALUABLE ITMES INCLUDING CLOTHING YOU BROUGHT WITH YOU TODAY:

Item	Gave to my family	Checked in Safe	Kept myself
Clothing			
Watch			
Jewelry			
Money			
Wallet			
Purse			
Credit cards			
Dentures			
Reading glasses			

DISCHARGE PLANNING:

44. WHO WILL BE TAKING YOU TO WHERE YOU ARE GOING AFTER THIS ADMISSION?

Do not know

I know, see name below

Name:_____

Telephone: (____) ____-____

Address:_____

45. DO YOU ANTICIPATE ANY PROBLEMS AT HOME OR WHERE YOU ARE GOING?
□ YES □ NO
I live alone
I am going to stay with my: family / children / relative / friends
I am going to a: after care facility / home / home with a nurse
The people where I am staying are not at home: days / afternoons / nights
Contacting the hospital in an emergency
Taking my medicine
Getting back to the doctor's office
Other:_____

46. DO YOU NEED A VISITING NURSE OR HOME HEALTH SERVICE? □ YES □ NO
Comments:_____

47. WHAT IS YOUR MAJOR CONCERN FOR THIS ADMISSION?

_____
_____
_____

48. WHAT DO YOU EXPECT TO BE THE RESULTS OF THIS TREATMENT?

_____
_____

CERTIFICATION OF AUTHENTICITY:

I hereby certify that the above information is true and correct within the best of my ability.

Signed:_____
Date:____/____/_____
Relationship: myself / parent / guardian / relative / friend