

Patient Name: _____ Date: _____

Emergency Contact: _____ Phone # _____

Name of Person accompanying patient home: _____ Phone # _____

Will escort remain at Center? Yes No Patient Age: _____ Height: _____ Weight: _____

Primary M.D.: _____ Surgeon/Physician for Procedure: _____

Primary Language: _____ Understands English YES NO Requires Translator YES NO

MEDICAL HISTORY: Check all that apply DENIES MEDICAL PROBLEMS

Neurology: Stroke _____ Seizures _____ Depression Head Injury Other _____
 NONE

Cardiovascular: MI/Heart Attack High Blood Pressure Mitral Valve Prolapse Chest Pain
 NONE Heart Valve Replacement _____ CHF Pacemaker Stent Open Heart Surgery _____
 Arrhythmia/Palpitations Internal Defibrillator Manufacturer: _____
 Vascular Disease Peripheral Vascular Disease Coronary Artery Disease _____

EENT: Glaucoma YES NO Loose Teeth YES NO Other _____
 NONE

Respiratory: Asthma _____ COPD/Emphysema Pneumonia _____ Bronchitis _____
 NONE Sleep Apnea Shortness of Breath Other: _____

Hepatic: Hepatitis Type (please circle) A B C Bleeding Disorder: Type _____
 NONE Other Liver Disease: Type _____

GI: GERD (Gastroesophageal Reflux Disease) Hiatal Hernia Ulcer _____ Crohn's/Colitis
 NONE History of Colon Polyps Recent change in Appetite/Weight Trouble Swallowing Other: _____

Renal: Prostate Dialysis, Date of Last Treatment: _____ Kidney Disease: Type _____
 NONE

Endocrine: Type I Diabetes (Insulin Dependent) Type II Diabetes (Non-Insulin Dependent) Thyroid Disease
 NONE

Cancer: Type: _____ Date & Type of Treatment: _____
 NONE

GYN: Last menstrual period: Date _____ Tubal Ligation/IUD Hysterectomy
 NONE

Musculoskeletal: Arthritis Fractures Back/Disk Disease Artificial Joint/Prosthetic: Type _____
 NONE Limited Motion of Neck TMJ - Limited Jaw Movement

SURGERIES/PROCEDURES: NONE

Procedure	Date

ALLERGIES: _____ **TYPE OF REACTION:** _____

Medicines Food Environmental Latex No Known Allergies

Patient / Label

MEDICATIONS: None See Attach List

Drug	Dosage	Last dosage
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

Aspirin in the last week YES NO
 Coumadin or Plavix in the last week YES NO
 Motrin, Aleve, Advil in the last week YES NO

TOBACCO: None _____ packs per day _____ # of years _____ Years Quit
ALCOHOL: None _____ Drinks per week Type: _____ _____ Years Quit
RECREATIONAL/STREET DRUGS: None Type: _____ _____ Years Quit
PREVIOUS ANESTHESIA: YES NO
 Problems with Anesthesia YES* NO Family History of Problems with Anesthesia YES* NO
 *Describe Problems: _____
RECENT EXPOSURE/SYMPTOMS TO INFECTIOUS DISEASE: Any History of Infectious Disease? YES* NO
 *List: _____ HIV/AIDS C-Diff Swine Flu/H1N1 TB MRSA Avian Flu
 Other _____

DO NOT WRITE BELOW THIS LINE - FOR ADMINISTRATIVE USE ONLY

DISPOSITION OF BELONGINGS

Jewelry Removed N/A YES NO

Dentures Removed N/A Upper Lower
 Both

Glasses/Contacts N/A Left Right
 Removed

Hearing Aid N/A Left Right
 Removed

Disposition of Belongings:
 At Bedside With Patient Family
 Managers Office

NURSES NOTES / COMMENTS / EXPLAIN ALL * ITEMS

CARE PLAN AND EDUCATIONAL TEACHING RECORD

NURSING DIAGNOSIS	PLAN / IMPLEMENT	EVALUATION
1. <input type="checkbox"/> Actual <input type="checkbox"/> Potential Knowledge deficit re: Pre & Post Procedure Patient Safety	<input type="checkbox"/> Orient to unit <input type="checkbox"/> Refer to physician/anesthesia provider for additional questions. <input type="checkbox"/> Provide information in layman's terms. <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient demonstrates greater knowledge of procedure, care and safety
2. <input type="checkbox"/> Actual <input type="checkbox"/> Potential Barriers to Learning related to: <input type="checkbox"/> Communication/Language <input type="checkbox"/> Ability to read/write <input type="checkbox"/> Physical status i.e. acute pain <input type="checkbox"/> Emotional Status <input type="checkbox"/> Impaired mental status <input type="checkbox"/> None - Ready to Learn	<input type="checkbox"/> Learning needs assessed. <input type="checkbox"/> Establish appropriate communication. <input type="checkbox"/> Provide education to patient/family/significant other when readiness to learn is established. <input type="checkbox"/> Other _____	<input type="checkbox"/> Safe discharge plan implemented <input type="checkbox"/> Learning needs met

Patient Signature Date

RN - Printed Name RN Signature Date / Time