DT527

Overlook Medical Center
ATLANTIC HEALTH SYSTEM

PATIENT SELF ASSESSMENT OF HEALTH HISTORY AND NEEDS

(Form completed by patient, family member, or significant other)

Patient's Name: _____ Birth Date: _____

Telephone # - Preferred: ( ) _____ Secondary: ( ) _____ Other: ( ) _____

May we call you if we have questions? ☐ Yes ☐ No May we leave a message? ☐ Yes ☐ No

May we e-mail you educational information? ☐ Yes ☐ No E-mail Address: _____

Date of Surgery: _____ Surgeon's Name: _____

What Surgery are you having? _____ Which side (if appropriate check one): ☐ Right ☐ Left

COMMUNICATION ASSESSMENT

Please check "YES" or "NO". Provide additional information when requested.

YES	NO	
☐	☐	Is English your preferred language to discuss your health?
		If "NO", what is the preferred language? _____
☐	☐	Do you have a hearing problem?
☐	☐	Do you use hearing aide(s)? If "Yes: check one: ☐ Right ear ☐ Left ear ☐ Both ears
☐	☐	Do you use eyeglasses?
☐	☐	Do you wear contact lenses?

MOBILITY ASSESSMENT

☐	☐	Do you use a cane, crutches, walker, or wheelchair? If "YES", which do you use? _____
☐	☐	Have you had a recent fall
☐	☐	Are you unsteady on your feet

HEIGHT AND WEIGHT

Your height: _____ feet _____ inches

Your weight: _____ lbs.

ALLERGIES

☐ ☐ **Do you have any allergies?**
If "YES", list allergy **AND** reaction [Example: Tetracycline – rash]:

MEDICATION ALLERGIES: _____

_____

FOODS ALLERGIES: _____

SEASONAL / ENVIRONMENTAL ALLERGIES: _____

☐ ☐ Are you allergic to LATEX?
If "YES", what is your reaction to LATEX? _____

MEDICATION LIST

List all medications you are currently taking, include aspirin, over-the-counter drugs, herbals and vitamins. Attach additional sheets if necessary:

MEDICATION NAME	DOSE	SPECIFIC TIME(S) TAKEN
EXAMPLE: Lipitor	10 mg	9:00 PM

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MEDICAL HISTORY

Do you now have (or have you had in the past) any of the following conditions?

If you check "YES", please circle the specific condition:

YES	NO	
☐	☐	**High Blood Pressure**
☐	☐	Cancer: • Location: _____ • Had Chemotherapy • Had Radiation Therapy
☐	☐	Cardiac Condition: • **Atrial Fibrillation** • Angina • **Arrhythmia (Abnormal heart rhythm)** • Congestive heart failure [CHF] • **Heart attack** • Heart murmur • **High Cholesterol** • High Triglycerides • Mitral valve prolapse • Pacemaker • Implanted defibrillator • Rheumatic fever • Coronary Artery Disease • Other: _____
☐	☐	Dermatological or Skin Condition: • Excema • Psoriasis • Rosacea • Skin ulcers • Other: _____
☐	☐	Endocrine Condition: • **Diabetes** • **Thyroid** • Other: _____
☐	☐	Stomach / Gastrointestinal Condition: • Crohn's Disease • Constipation • Diarrhea • Diverticulitis • Diverticulosis • Reflux / GERD • Hemorrhoids • Hepatitis (if known circle type A / B / C) • Hernia (other than Hiatal) • Hiatal Hernia • Irritable Bowel Syndrome /IBS • Lactose Intolerance • Liver Disease • Morbid obesity • Polyps • Colostomy • Ulcer • Gall Bladder Disease • Other: _____
☐	☐	Kidney / Urinary Tract Condition: • Enlarged Prostate (BPH / Benign) • Prolapsed bladder • Urgency • Frequency • Incontinent • Cystitis • Kidney stones • **Kidney failure** • On hemodialysis • On peritoneal dialysis • Ostomy • Other: _____
☐	☐	Gynecological Condition: • Bartholin cysts • Endometriosis • Ovarian cysts • Fibroids • Post menopausal Bleeding • Other: _____
☐	☐	Are you a female who gets her period? • Date of last period: _____
☐	☐	Hematologic / Blood Condition: • **Anemia** • Bleeding disorder • **Blood clot(s)** • **Bruise easily** • Sickle Cell Disease • Other: _____
☐	☐	Neurological Condition: • Alzheimer's • Cerebral Palsy • **Stroke / CVA** • Fainting • Headaches • Migraine headaches • Multiple sclerosis • Paralysis • Parkinson's Disease • **Numbness / Tingling** • Seizures • Mini-Stroke / TIA • Vertigo • Tremors • **Weakness** • Other: _____
☐	☐	Eye Condition: • Blindness • Cataract(s) • Glaucoma • Macular Degeneration • Other: _____
☐	☐	Orthopedic Condition: • **Chronic back pain** • **Chronic neck pain** • Contractures • Fibromyalgia • Fractures • Gout • Osteoarthritis • Rheumatoid arthritis • Scoliosis • Herniated disc • Osteoporosis • Osteopenia • Other: _____
☐	☐	Vascular and Other Condition(s): • HIV • Lupus • Lyme disease • Peripheral vascular disease • Sarcoidosis • Other: _____
☐	☐	Psychiatric Condition: • Attention deficit disorder • Anxiety • Bipolar • Dementia • Depression • Obsessive compulsive disorder • Panic attacks • Schizophrenia • Other: _____


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YES	NO	
☐	☐	Respiratory / Lung Condition:

• **Asthma** • Bronchitis • Chronic cough • **COPD** • Emphysema • Pneumonia • Sinus problems • **Sleep apnea**
• C-PAP • **Shortness of breath** • Tuberculosis / TB • Other: _____

OBSTRUCTIVE SLEEP APNEA ASSESSMENT

☐ ☐ Has your weight changed.
☐ ☐ How often have you or someone else noticed your breathing pauses when you sleep? _____
☐ ☐ Are you still tired after sleeping?
☐ ☐ Are you tired during your awake time?
☐ ☐ Have you fallen asleep while driving?
☐ ☐ Do you have high blood pressure?
☐ ☐ Do you snore or have you been told you snore?
☐ ☐ How frequent is your snoring?
☐ ☐ Does your snoring bother others?
☐ ☐ Is your snoring loud enough to be heard through a closed door?

MEDICAL HOSPITALIZATIONS

☐ ☐ Have you ever been admitted to a hospital for treatment of a medical condition?

If "YES", what was the medical condition **AND** what was the year hospitalized (if known)?

[Example: Pneumonia – 2003]._____

_____

SURGICAL HISTORY QUESTIONS

☐ ☐ Have you or a close family member had problems when receiving anesthesia?

If "YES", explain: _____

☐ ☐ Do you have a PACEMAKER? If known, Make: _____ Model: _____
☐ ☐ Do you have an IMPLANTED DEFIBRILLATOR? Make: _____ Model: _____
☐ ☐ Do you have any implants?

If "YES", explain: _____

SURGICAL HISTORY LIST

List previous operations. Include the year the operation was done (if known):

[Example: Hernia repaired – 2003]._____

_____

_____

_____

☐ ☐ Have you ever received a blood transfusion: _____
☐ ☐ Reaction to blood transfusion: _____
☐ ☐ Religious cultural preferences that prevent blood transfusions: _____

DISEASE EXPOSURE AND IMMUNIZATION

☐ ☐ In ***JUST THE PAST MONTH,*** have you been exposed to any communicable diseases like Chicken Pox. Measles, Mumps, or TB?

If "YES", explain: _____

☐ ☐ Have you received the Flu Vaccine?

If "YES", the approximate date was: _____

☐ ☐ Have you received the Pneumonia Vaccine?

If "YES", the approximate date was: _____

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LIFE STYLE FACTORS

YES	NO	
☐	☐	Do you currently **smoke**? Current smoker - amount smoked (pack/day): _____
☐	☐	Did you ever smoke?
		Year stopped?_____
☐	☐	Do you **drink alcohol** (wine / beer / hard alcohol) regularly (at least once a week)?
		How many drinks of each per week: Wine: _____ Beer: _____ Hard Alcohol: _____
☐	☐	Do you currently use **recreational drug(s)**?
		If "YES", what drug(s) do you use: _____ How often? _____ How much? _____
☐	☐	Have you used recreational drug(s)in the past? Have you had problem with substance abuse?
		If "YES", what drug(s) did you use: _____ How often? _____ How much? _____
		Year stopped? _____
☐	☐	Does anyone live with you?
		If "YES", who lives with you? _____
☐	☐	Does anyone depend on you for their care?
☐	☐	Have you made arrangements for someone to drive you home after surgery?
		If "YES":
		Their name: _____
		Their phone / cell phone number (s): _____

YOUR PHYSICIANS

Primary Care Physician's Name: _____ **Phone:** _____

Cardiologist's Name: _____ **Phone:** _____

Thank you for taking the time to complete this questionnaire.

Please mail the questionnaire immediately in the stamped, self-addressed envelope if your surgery is **more** than a week away. If your surgery is **less** than a week away, please bring the questionnaire with you on your day of surgery or, fax the questionnaire to 866-501-7192.

Your signature: _____ Date/Time completed:_____

If you are not the patient, please fill-in your relationship to the patient: _____

FOR OFFICE USE ONLY

Document completed with patient by: _____ RN Date/Time: _____

Document reviewed by: _____ RN Date/Time: _____