

Dear Patient,

To help us plan your care, please answer the following question about your medical and surgical history.

ARE YOU ALLERGIC TO ANYTHING? (DRUGS, FOOD, LATEX)

RESPIRATORY SYSTEM	Yes	No	MUSCLE & SKELETAL SYSTEM	Yes	No
COPD, Emphysema, Bronchitis, or Asthma			Arthritis		
Tuberculosis Exposure Date _____			Back or neck problems		
O2 use at home			Muscle weakness, numbness, paralysis		
Sleep Apnea <input type="checkbox"/> CPAP <input type="checkbox"/> BIPAP			History of broken bones / pins or screws		
Tobacco use <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chew <input type="checkbox"/> Other Amount per day _____ Number of years _____			KIDNEY & REPRODUCTIVE		
			Kidney disease		
CARDIAC SYSTEM			Problems urinating		
Heart condition Describe _____			Prostate problems <input type="checkbox"/> N/A		
Angina / Chest pains Last Episode _____			Female problems <input type="checkbox"/> N/A		
History of heart attack Date _____			Pregnant / think you might be pregnant		
High or low blood pressure			Date of your last menstrual period: _____		
Pacemaker / Stent			BLOOD BORNE & INFECTIOUS		
Rheumatic fever /Heart murmur or valve disease			Cancer: Type: Date _____		
Self / family history of blood clots			Blood/Bleeding disorders List _____		
Swelling or edema of hands or feet			Blood transfusions Date _____		
STOMACH & BOWEL			HIV / AIDS, Hepatitis etc..		
Unexplained weight loss or weight gain			OTHER		
Reflux / GERD			Recent cold, flu or other infection		
Diabetes			Have you or anyone in your household have or had MRSA, VRE (antibiotic resistant organism)		
Nausea or vomiting / diarrhea or constipation			Recent exposure to communicable diseases		
Feeding Tube / nutritional supplement			If under 18 yrs are immunizations current?		
Liver problems Describe _____			SOCIAL / SPIRITUAL /		
Hernia Where _____			Depression or anxiety		
BRAIN & NERVOUS SYSTEM			Is anyone at home hurting you?		
Chronic headaches, dizziness, or motion			Do you drink alcohol? If yes, how often?		
Stroke Date _____			Do you use street drugs? If so, what kind?		
Seizures Date of last episode _____			Do you have any special spiritual or cultural needs Describe _____		
Cerebral Palsy, Multiple Sclerosis			List any operations:		
Glaucoma, Cataracts			Any problems with anesthesia Describe _____		
List other illnesses / hospitalizations			List important family medical history		

List all of your medications



Medical and Surgical
History

***VMR-[CaseId]-866-**

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CaseID: [CaseId] Acct: [PatientId]
[PatientLast], [PatientFirst] DOS:
[DOS]
DOB: [DOB] Age: [Age] Sex: [Sex]
[PhyFirst] [PhyLast]

**Include herbs, aspirin and other non-prescription drugs
List any medications you have recently taken, such as steroids, blood thinners, or
antibiotics**

Name of Medicine	Dosage	Times per Day	Next Dose Due

See Medication Reconciliation Form or Attached List

****Please Check Any Valuables You Brought To The Facility****

<u>VALUABLES</u>	Valuables Disposition		
	Family	Locker	Belongings Bag
Dentures Upper			
Dentures Lower			
Eye Glasses			
Contact lenses			
Hearing Aid			
Jewelry			
Money			
Credit Cards			

Other items

The items listed above have been reviewed and returned to me or designated party. Signature _____

List an emergency contact: _____ **Relationship to patient** _____

Emergency contact phone number _____ **This form completed by:** _____

Pre-Op Nurse:	Post-Op Nurse:
Intra-Op Nurse:	Date:
Pre-Op Nurse:	Post-Op Nurse:
Intra-Op Nurse:	Updated:
Pre-Op Nurse:	Post-Op Nurse:
Intra-Op Nurse:	Updated:
Pre-Op Nurse:	Post-Op Nurse:
Intra-Op Nurse:	Updated: