3200338

BAILEY MEDICAL CENTER
OWASSO, OKLAHOMA 74055

This assessment is designed to give you better and more efficient medical care
If you are completing this form for a child under the age of twelve, please proceed directly to Section A.
If you are completing this form in anticipation of a spinal narcotic or epidural for labor, please proceed directly to Section B ***after completing the General Section below.***
If you are completing this form in preparation for surgery or other medical procedure, please fill out the General Section.

General Health Information Section

Circle yes or no

	Yes	*No*	Are you allergic to latex?
	Yes	*No*	Are you allergic to eggs, soy products, or shellfish?
HCG	*Yes*	*No*	Is there any chance that you could be pregnant?
			When was the first day of your last menstrual period? ___/___/___?
	Yes	*No*	Was it normal?
	Yes	*No*	Are you allergic to any medications?
			If yes, please list the medications and the nature of the reaction below.

Medication ____________ *Reaction* ____________

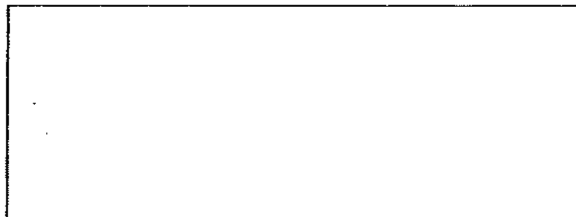
	Yes	*No*	Have you used oral steroids (Prednisone, Medrol) for more than 3 consecutive weeks in the past year?
	Yes	*No*	Are you taking any medications, including over the counter or herbal products? If so, please list the medications below.

Medication *Dose* *How many times/day*

BMP-steroids
Diuretics

	Yes	*No*	Are you taking diet pills?
	Yes	*No*	Are you using any "street drugs"? If so, ____________ drug, ____________ when last used.
BMP	*Yes*	*No*	Have you changed to a non-protein diet at the direction of a physician?
	Yes	*No*	Have you ever had surgery or other medical procedure requiring anesthesia? Please list:
	Yes	*No*	Did you have any problems with the anesthetic in the above procedures? Explain:
	Yes	*No*	Were you ever told that you were difficult to intubate (put the breathing tube in)?
	Yes	*No*	Has anyone in your biological family had problems with anesthetics? Please explain:

Reviewed by ____________ RN



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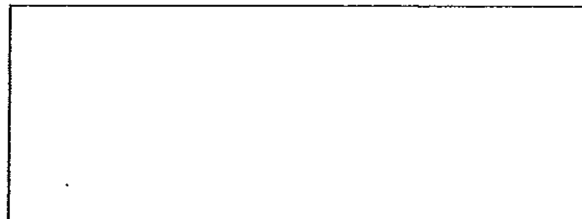
	Yes	*No*	Has anyone in your biological family had to be on a breathing machine (ventilator) unexpectedly following surgery?
	Yes	*No*	Do you have any endocrine disorders such as _____ thyroid disease or _____ adrenal insufficiency?
BMP	*Yes*	*No*	Do you have diabetes? ______ Non-insulin dependent _______ Insulin dependent
CXR	*Yes*	*No*	Have you ever been diagnosed with _____ diptheria or ______ thyroid goiter (enlarged goiter)?
	Yes	*No*	Do you have ______ allergies or ______ sinus problems?
	Yes	*No*	Have you ever had a broken _______ neck, _______ nose, _______ or jaw?
	Yes	*No*	Do you have obstructive sleep apnea? If so, do you use a ______ Bipap or ______ CPAP?
CXR	*Yes*	*No*	Do you have any lung disease such as _____ asthma, _____ emphysema, ______ COPD, or _____ chronic bronchitis?
CXR	*Yes*	*No*	Do you have a productive cough?
CXR	*Yes*	*No*	Has there been a change in your sputum color in the past week?
CXR	*Yes*	*No*	Have you traveled to an area of high risk for tuberculosis or been exposed to TB?
CXR			When was your last chest x-ray? ______________
	Yes	*No*	Have you had any _____ cough, _____ cold, _____ fever, _____ chills or ______ upper respiratory infection in the last six weeks?
	Yes	*No*	Have you ever smoked or used tobacco?
CBC			_______________ Packs per day.
			Quit ___________ years ago.
	Yes	*No*	Have you had to use an inhaler within the past week?
	Yes	*No*	Do you drink alcohol? If so ______ # Drinks per Day / Week / Month
CMP	*Yes*	*No*	Have you ever had a problem with alcohol?
CMP	*Yes*	*No*	Have you ever had liver or biliary disease?
CMP	*Yes*	*No*	Have you ever had hepatitis? If so, what type? _____________
CMP	*Yes*	*No*	Have you been exposed to anyone with yellow jaundice or hepatitis in last 6 months?
CMP, PT, PTT	*Yes*	*No*	Do you have prolonged or unusual bleeding from cuts?
CMP, PT, PTT	*Yes*	*No*	Have you noticed any increased bruising?
PT, PTT	*Yes*	*No*	Are you taking any blood thinners?
PT, PTT	*Yes*	*No*	Does anyone in your biological family have a bleeding disorder such as ______ hemophilia, ______ VonWillebrand's disease, ______ Leiden factor deficiency, or ______ Substance P deficiency?
	Yes	*No*	Is there any history of sickle cell disease or thalassemia in your biological family?
	Yes	*No*	Do have any false, loose, capped teeth or dentures/partials?
CMP	*Yes*	*No*	Has your body weight changed by 15% or more in the past year?
BMP	*Yes*	*No*	Is your body weight 100 pounds or more over your ideal body weight?
	Yes	*No*	Have you ever vomited blood?
	Yes	*No*	Do you have acid reflux?
	Yes	*No*	Do you have peptic ulcer disease?
	Yes	*No*	If you lay down after a meal, does something like hot water run up into your mouth?
CMP, PT, PTT	*Yes*	*No*	Have you vomited blood or material that looks like coffee grounds?
	Yes	*No*	Do you have to elevate the head of your bed?
	Yes	*No*	Do you have a hiatal hernia?
	Yes	*No*	Do you have heartburn? _____ Rarely _____ Occasionally _____ Frequently
	Yes	*No*	Do you use antacids (TUMS, Rolaids, Maalox, etc.) on a regular basis?
	Yes	*No*	Do you have any difficulty swallowing liquids?
	Yes	*No*	Does your food seem to hang up in your esophagus?
BMP	*Yes*	*No*	Do you have kidney disease other than the occasional bladder infection?
	Yes	*No*	Have you had kidney stones?
	Yes	*No*	Do you get up at night to empty your bladder?
	Yes	*No*	Do you have _____ high blood pressure or _____ low blood pressure?
CXR, EKG	*Yes*	*No*	Do you have heart disease?
EKG	*Yes*	*No*	Have you ever had a heart attack? If so, when? ______________________

Reviewed by _______________ RN



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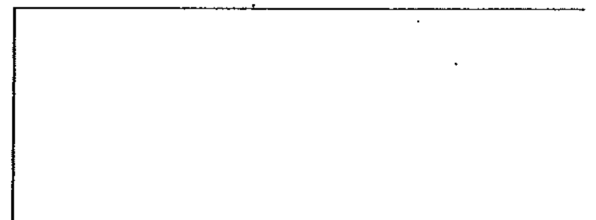
ANESTHESIA
PATIENT QUESTIONNAIRE

200338 (08/09)

CBC	*Yes*	*No*	Have you ever had a surgical procedure performed on your chest?
EKG	*Yes*	*No*	Do you have chest pain when you exert yourself or get excited?
EKG	*Yes*	*No*	Do you have angina?
	Yes	*No*	Do you become short of breath with activity such as walking up two flights of stairs or vacuuming?
	Yes	*No*	Do you need to sleep on more than one pillow? If so, how many? ___________
CBC	*Yes*	*No*	Have you been anemic (low red blood cell count)?
	Yes	*No*	Do you awaken at night short of breath?
	Yes	*No*	Have you had new onset of ankle swelling?
	Yes	*No*	Do your legs ache so much when you walk that you have to stop and rest before resuming your walk?
EKG	*Yes*	*No*	Do you have congestive heart failure or an enlarged heart?
	Yes	*No*	Have you ever had a heart murmur?
EKG	*Yes*	*No*	Do you have an arrhythmia (abnormal heart rhythm) or do you feel irregular forceful heart beats?
EKG	*Yes*	*No*	Do you have mitral valve prolapse?
EKG	*Yes*	*No*	Do you have a pacemaker or internal cardiac defibrillator?
	Yes	*No*	Do you have any history of neurologic disease such as _____ stroke, _____ seizures, _____ multiple sclerosis, _____ neuropathies?
	Yes	*No*	Have you had any blackouts or fainting spells in the past year?
BMP	*Yes*	*No*	Have you ever had a seizure? If so, when was the last seizure? ____________
BMP	*Yes*	*No*	Have you ever had a stroke? If so, when? _____________ Any residual effects? ____________
BMP	*Yes*	*No*	Do you have _____ headaches or _____ migraines? How often? _____ day / week / month
BMP	*Yes*	*No*	Have you ever had any spinal cord injury?
BMP	*Yes*	*No*	Do you have any type of congenital neurologic condition?
	Yes	*No*	Have you ever had rheumatic fever?
	Yes	*No*	Do you have any acute or chronic pain currently? If so, where? ____________ We use a numerical pain scale rating from 0 - being no pain - to - 10 -being **very** severe pain. Please rate your current pain _____. Please report pain during your hospital stay using this scale as your comfort is very important to us.
	Yes	*No*	Do you have _____ arthritis or _____ chronic back pain?
CXR	*Yes*	*No*	Do you have Rheumatoid arthritis? If so, does it affect your neck? ____________
	Yes	*No*	Do you have temporomandibular joint dysfunction (TMJ)?
	Yes	*No*	When you look up high and extend your head backward, does your vision dim?
	Yes	*No*	Do you have any muscle diseases?
	Yes	*No*	Has anyone in your biological family had malignant hyperthermia or malignant neurolept syndrome or muscular dystrophy?
CBC	*Yes*	*No*	Have you had cancer or leukemia? If so, have you received ______ chemo or ______ radiation?
CXR	*Yes*	*No*	Have you ever had a malignancy (other than basal cell carcinoma) in the past?
CMP	*Yes*	*No*	Have you been admitted to the hospital in the past year?
	Yes	*No*	Do you have any history of falling?
	Yes	*No*	Have you had significant ***unexpected*** weight gain/loss or other nutritional concerns?
	Yes	*No*	Do you have any functional difficulties walking, dressing, bathing, etc.?
	Yes	*No*	Do you have any spiritual or cultural beliefs that we need to be aware of that may affect your health care?
	Yes	*No*	Do you have a preference on learning? (ex. Reading, listening, videos, etc. ____________
	Yes	*No*	Do you have an advanced directive or living will that concerns your health care wishes of which we need to be aware?
	Yes	*No*	Do you have any additional health information not covered above that we may need to be aware of? Please explain: ____________

Reviewed by ________________ RN

CXR>75, BMP>65, CMP>75, CBC>40 or F>12



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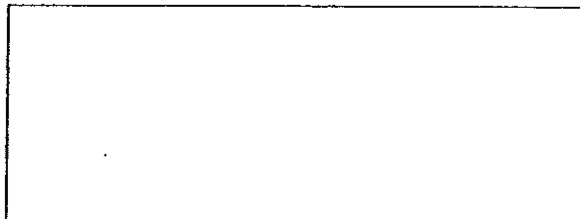
Section A

Yes	*No*	Does some other than you have legal custody of this child?
Yes	*No*	Was your child born premature by more than two weeks?
Yes	*No*	Was your child ever on a ventilator?
Yes	*No*	Has your child been on an apnea or bradycardia monitor? If so, when was it discontinued? ______
Yes	*No*	Has your child missed any developmental milestones?
Yes	*No*	Is your child allergic to latex?
Yes	*No*	Does your child have cerebral palsy or Down's syndrome?
Yes	*No*	Does you child have problems with reflex of gastric contents?
Yes	*No*	Is your child under 8 years old, if so what percentile is he/she for ______ height and ______ weight?
Yes	*No*	Has your child ever had a urinary catheter?
Yes	*No*	Has your child had a respiratory infection in the past 6 weeks?
Yes	*No*	Does your child have hydrocephalus?
Yes	*No*	Has your child had seizures?
Yes	*No*	Has your child had a heart murmur?
Yes	*No*	Does your child have asthma?
Yes	*No*	Has your child had hepatitis?
Yes	*No*	Does you child have any kidney disease?
Yes	*No*	Does your child have any endocrine problems?
Yes	*No*	Has anyone suggested that your child might have a muscle disease?
Yes	*No*	Does your child have eye muscle imbalance?
Yes	*No*	Does your child have any loose teeth?
Yes	*No*	When was the last time your child had anything to eat?



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Section B

Age: ___________ Height: ___________ Weight: (at present) ___________
How many pregnancies have you had? _______ How many vaginal deliveries have you had? _______
When is your baby due? ___________________

Yes *No* Have you ever had a C-section?
Yes *No* Do you have an allergy to latex?
Yes *No* Are you allergic to any medications? If so, please list:

Medication *Reaction*

Yes *No* Are you allergic to any foods? If so, please list: ___________________

If this is not your first delivery, please list how your labor pain was managed? (i.e. spinal narcotic, epidural, intravenous analgesics, natural)

1st delivery: ___________________
2nd delivery: ___________________
3rd delivery: ___________________
4th delivery: ___________________

How long was your last labor? ___________ *hours*

Yes *No* Have there been any complications with this pregnancy or previous pregnancies? Please describe:

Yes *No* Does anyone in your biological family have a bleeding disorder?

Patient Signature ___________________ *Date* ___________

Reviewed by ___________________ *DO/MD*