University of Colorado Hospital

PRE-PROCEDURE and ADMISSION SCREENINGS

PATIENT INFORMATION

Home phone ____________________________ Work _______________________ Local/cell number _____________________

Would it be best to call you at ❑ home ❑ work Can we leave a message? ❑ Yes ❑ No

Home address ________________________________ City ________________ State ______

E-mail ____

Primary care physician _______________________________________ Phone ________________ Fax __________________

Emergency contact ________________________________ Relation ____________________ Phone ______________________

ADMISSION SCREENINGS

ALLERGIES	**Reaction**		**Reaction**	**Other Allergies**	**Reaction**
❑ No known		❑ Contrast dye	______________	❑ Banana	__________________
❑ Penicillin	______________	❑Fish/shellfish	______________	❑ Kiwi	__________________
❑ Sulfa	______________	❑ Avocado	______________	__________________	__________________
❑ Latex	______________	❑ Chestnuts	______________	__________________	__________________

Communication

Check all that apply

❑ Speak English ❑ Understand English

❑ Read English ❑ Speak Spanish

Other language ______________________________

____

Have you ever been told you have an infection that is resistant to antibiotics? ❑No ❑Yes

If yes, ❑ MRSA ❑ VRE ❑ other_____ ❑ Don't know

If patient answers yes, send notification to UCH Infection Control Team

Psycho/Social

Do you smoke? ❑ No ❑ Yes **Ever smoked?** ❑ No ❑Yes

If so, ______________ packs / per day / for _____________ yrs

Quit in the last 12 months ❑ No ❑Yes

Do you drink alcohol? ❑ No ❑ Yes

how much _______________ how long __________________

Are you currently using recreational drugs?

❑ No ❑ Yes

Do you have any body piercing? ❑ No ❑ Yes If so, where ____

PREPROCEDURE SCREENING

Have you or anyone in your family had problems with general anesthesia?

❑ no

❑ yes

If yes, describe ❑you ❑family member

____

____

____

____

Do you have or have you had?

❑ problems bending your neck

❑ problems opening your mouth

❑ head injury ❑ seizure disorder

❑ stroke / TIA ("mini stroke")

❑ liver disease ❑ hepatitis ❑ HIV

❑ diabetes

❑ kidney disease

❑ thyroid disease

❑ rheumatoid arthritis ❑ osteoarthritis

❑ GERD/reflux/heartburn

❑ cancer –what kind_____________

❑ trouble breathing lying flat

❑ asthma

❑ shortness of breath

❑ shortness of breath on exertion

❑ lung disease ❑emphysema

❑ use oxygen

❑ sleep apnea ❑ use CPAP

❑ told I snore

❑ frequently tired during the day

❑ told I stop breathing when asleep

❑ high blood pressure

❑ take blood pressure medication

❑ irregular heart beats

❑ heart attack

❑ heart surgery

❑ blood clots

❑ abnormal EKG

❑ high cholesterol

❑ chest pain /pressure/angina

Explain- ____________________

❑ heart murmur

❑ abnormal heart stress test

When________ Where__________

❑ abnormal heart ultrasound

When________ Where__________

❑ pacemaker/internal defibrillator

→ Type/model of pacemaker________

Are you

❑ Under the care of a heart doctor

Name_________________________

Phone #________________________

❑ **No items apply**

List past surgeries/medical issues

____________________ Date______

____________________ Date______

____________________ Date______

____________________ Date______

____________________ Date______

____________________ Date______

Height________ Weight________

Important note-

Please see back side to list your medications →→→

Current Home Medications

(Include prescriptions, herbals, over-the-counter drugs, inhalers, patches, pumps, etc.)

IF you have a list of your medications please provide this to your provider and they will make a copy or be sure it is entered into the computer system.

Medication Name	**Dose** (Strength or concentration)	**Route** (By Mouth, Injection, etc.)	**Frequency** How many times a day do you take this?	**Indication** Why are you taking this?

PATIENT SIGNATURE ____ Date _______

The above information has been reviewed and verified with the patient

Clinic RN SIGNATURE ____ Date _______