COOKEVILLE REGIONAL MEDICAL CENTER

Pre-Admission Testing History Form

PATIENT INSTRUCTIONS: Please bring this completed form with you to your Pre-Admission testing appointment.

PERSONAL INFORMATION:

Patient Name: _____ Date of Admission: _____

Scheduled Procedure: _____

Person providing information if other than patient: _____ Relationship to patient: _____

Language spoken: ❑ English ❑ Other: _____ Is an interpreter needed: ❑ Yes ❑ No

Name and phone number of interpreter: _____

Highest Grade Completed: _____

Do you have a living will? ❑ Yes ❑ No ❑ Unknown

Do you have a durable power of attorney for healthcare? ❑ Yes ❑ No

If "yes": Name: _____ Phone #: _____
(If "yes" to above question, please bring a copy to the hospital on admission)

Are you an Organ Donor? ❑ Yes ❑ No

Primary Physician: _____ Phone #: _____

Have you ever had a: ❑ Cardiac Cath ❑ Stress Test ❑ EKG/ECG ❑ ECHO ❑ Been seen by a cardiologist
(If you checked any of the boxes, please fill in the information below)

Name of Cardiologist: _____ Name of Facility: _____

PREVIOUS SURGERIES	
SURGERY	YEAR

ALLERGIES:

❑ None ❑ Medications ❑ Latex ❑ Food

ALLERGY	REACTION
Other:	

CANCER		
WHAT TYPE	YEAR	WHAT TYPE OF TREATMENT RECEIVED

DIALYSIS: ❑ Peritoneal Dialysis ❑ Dialysis: What day do you go? _____

IMMUNIZATIONS: ❑ Flu Vaccine / Yr_____ ❑ Pneumonia Vaccine / Yr_____

Height: _____ Current Weight: _____ ❑ Actual ❑ Estimated

ALCOHOL USE: ❑ Yes ❑ No ❑ Occasional

❑ Beer ❑ Liquor ❑ Wine ❑ Other: _____

❑ Drinks socially _____per/ day _____per/ week

TOBACCO USE: ❑ Yes ❑ No ❑ Past ❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Chew

When did you quit? _____ How many years smoked? _____

How many packs? _____ How many years of tobacco (chew) use? _____

How many cigarettes do you smoke a day? _____

ILLEGAL DRUG USE: ❑ Never ❑ Past ❑ Now _____

Medications Taken Regularly (Prescription, Over-The-Counter, Home Remedies): ❑ None

****PLEASE BRING ALL MEDICATIONS YOU ARE CURRENTLY TAKING IN ORIGINAL BOTTLES****

NAME OF MEDICATION	DOSE	FREQUENCY
HERBAL PREPARATIONS		

Have you had any changes in medications in the past 30 days? ❑ Yes ❑ No

DENTAL HISTORY		
❑ No problem ❑ Braces ❑ Bridges ❑ Broken Teeth	❑ Caps ❑ Implants ❑ Loose Teeth	❑ Dentures: ❑ Upper ❑ Full ❑ Partial ❑ Lower ❑ Full ❑ Partial ❑ Other: _____
NUTRITION		
❑ No problem ❑ No restrictions **Special Diet:** ❑ Cardiac ❑ Chopped / Soft	❑ Cultural-Specific Diet ❑ Diabetic ❑ Feeding Tube ❑ Fluid Restriction ❑ Kosher	❑ Low Salt Diet ❑ Renal ❑ Thick It ❑ Vegetarian

Have you lost weight recently without trying? ❑ Yes ❑ No ❑ Unsure

If yes, how much weight have you lost? ❑ 1 - 5 lbs ❑ > 15 lbs ❑ 6 - 10 lbs ❑ 11 - 15 lbs

RESPIRATION / LUNG:

- ❑ No problem
- ❑ Asthma
  *Last episode when:*_____
- ❑ Chronic Bronchitis
  *Last episode when:*_____
- ❑ Other: _____
- ❑ Emphysema
- ❑ Loud Snoring
- ❑ Pneumonia: *when*_____
- ❑ Tracheotomy
- ❑ Positive TB Test: *when*_____
- ❑ Recent Cold or Flu
- ❑ Orthopnea:
  Do you sleep with more than two pillows under your head? ❑ Yes ❑ No
- ❑ Wheezing
- ❑ Shortness of Breath
- ❑ Sleep Apnea
- ❑ C-Pap / Bi-Pap: when started

Have you been hospitalized or seen in the ER for Asthma? ❑ Yes ❑ No If yes, when _____
Inhaler ❑ Yes ❑ No Medications ❑ Yes ❑ No How far can you walk before you are short of breath_____

VASCULAR / HEART:

- ❑ No problem
- ❑ Abnormal EKG: *when*_____
- ❑ Blood Clots: *when*_____*where*_____
- ❑ Chest Pain
- ❑ Chest Pressure
- ❑ Congestive Heart Failure:
- ❑ Circulation Problems
- ❑ Fainting Episodes
- ❑ Heart Attack/MI
- ❑ Heart Blockage
- ❑ Heart Murmur
- ❑ High/Low Blood Pressure
- ❑ Valve Disorder
- ❑ Internal Defibrillator
- ❑ Irregular Heart Beat
- ❑ Pacemaker
- ❑ Palpitations
- ❑ Phlebitis
- ❑ Swelling of Feet / Ankles / Legs
- ❑ Varicose Veins
- ❑ Other: _____

Have you been hospitalized with Congestive Heart Failure? ❑ Yes ❑ No If yes, when _____

If Chest Pain checked: Where do you have it? Check all that apply ❑ Mid Chest ❑ Shoulder ❑ Arm ❑ Jaw ❑ Neck ❑ Back

Feels like: ❑ Tightness ❑ Squeezing ❑ Crushing ❑ Burning ❑ Choking ❑ Aching

When do you have it? ❑ Upon Exertion or Stress ❑ At Rest ❑ Other : _____

Is it steady pain? ❑ Yes ❑ No Does it go away when you take medicine? ❑ Yes ❑ No

Do you have: Shortness of breath ❑ Yes ❑ No Sweating ❑ Yes ❑ No Other:_____

GASTROINTESTINAL / BOWEL / DIGESTIVE

- ❑ No problem
- ❑ Bowel Obstruction
- ❑ Chronic Diarrhea
- ❑ Cirrhosis of Liver
- ❑ Colitis
- ❑ Colostomy
- ❑ Other: _____
- ❑ Constipation
- ❑ Crohn's Disease
- ❑ Excessive Burping
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Hiatal Hernia
- ❑ Irritable Bowel
- ❑ Rectal Bleeding
- ❑ Nausea / Vomiting
- ❑ Ulcer
- ❑ Jaundice
- ❑ Pancreatitis

If diagnosed with Hepatitis what type? ❑ A ❑ B ❑ C *When?*_____

MUSCULOSKELETAL

- ❑ No problem
- ❑ Arthritis
- ❑ Artificial Joint(s)
- ❑ Gout
- ❑ Lupus
- ❑ Muscular Dystrophy/Multiple Sclerosis *self/family*
- ❑ Fracture
- ❑ Muscle Weakness
- ❑ Osteoporosis
- ❑ Pins, Rods, Internal
- ❑ Sciatica
- ❑ TMJ Pain or Jaw Disorder *click/lock*
- ❑ Other: _____

ENDOCRINE

- ❑ No problem
- ❑ Diabetes
- ❑ Hormone Disorder
- ❑ Low Blood Sugar
- ❑ Thyroid Disorder
- ❑ Other: _____

BLOOD

- ❑ No problem
- ❑ Anemia
- ❑ Blood Transfusion: *when*_____
- ❑ Easy Bruising
- ❑ Frequent Nosebleeds
- ❑ Immuno-suppressed
- ❑ Other: _____

PSYCHIATRIC

❑ No problem	❑ Depression	❑ Mood Swings
❑ Anger	❑ Eating Disorder	❑ Schizophrenia
❑ Anxiety	❑ Hallucinations	❑ Suicide Attempt
❑ Dementia	❑ Manic Depression	❑ Other: _____

SKIN

❑ No problem	❑ Non-Healing Sores	❑ Shingles
❑ Bed Sore	❑ Rashes	❑ Skin Disorder
❑ Other: _____	❑ Ulcerations	❑ Skin Cancer

URINARY / REPRODUCTIVE

❑ No problem	❑ Loss of Control	**Females:**
❑ Blood in Urine	❑ Pain	Last Menstrual Period:_____
❑ Burning	❑ Prostate Problems (males)	Pregnant:
❑ Difficult Urination	❑ Self Catheterization	❑ Yes ❑ No ❑ Unsure
❑ Frequent Urination	❑ Sexually Transmitted Diseases	Weeks Pregnant: _____
❑ Infections	❑ Urinary Catheter (presently)	Due Date: _____
❑ Kidney Stones	❑ Ureterostomy	❑ Breast Feeding

EYES / EARS / NOSE / THROAT

❑ No problem	❑ Corneal Implants	❑ Hearing Impairment
❑ Blind	❑ Deaf	❑ Ringing in Ears
❑ Cataracts	❑ Deviated Septum	❑ Sinus Problems
❑ Contact Lenses	❑ Glasses	❑ TTY needed
❑ Other: _____	❑ Glaucoma	❑ Hard of hearing
	❑ Hearing Aids	

NEUROLOGICAL / BRAIN / SPINAL CORD

❑ No problem	❑ Dizziness	❑ Numbness
❑ Alzheimer's	❑ Fainting	❑ Paralysis of Arm / Leg L R
❑ Back Pain	❑ Frequent Headache	❑ Seizures: *last one when*_____
❑ Difficulty Learning	❑ Memory Problems	❑ Severe Headaches
❑ Difficulty Speaking	❑ Migraine	❑ Speech Slurred
❑ Tingling of Arm L or R	❑ Mini Stroke	❑ Stroke: *when*_____
❑ Tingling of Leg L or R	❑ Weakness	❑ Other:_____
❑ Difficulty with Balance	❑ Neck Pain	

If you have had a stroke do you have residual weakness? ❑No ❑Yes If yes, where_____

FAMILY HEALTH HISTORY	AGE DECEASED	HEART DISEASE	STROKE	DIABETES	CANCER / WHAT KIND
Mother					
Father					
Brother(s)					
Sister(s)					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					

ANESTHESIA

❑ No problem	❑ Difficult intubation, problems with airway, breathing	❑ Blood relative required ventilator after surgery
❑ Never had Anesthesia	❑ Difficulty waking up from Anesthesia	❑ Severe nausea after surgery
❑ You or a blood relative had unexplained fever right after surgery that ended up in ICU	❑ You required ventilator after surgery	❑ Pseudocholinesterase Deficiency