COOKEVILLE REGIONAL MEDICAL CENTER

SAME DAY SURGERY

Patient Name: ______________________________

Date of Admission or Procedure: ______________________________

PATIENT INSTRUCTIONS:
Please complete all sections on each page or have someone complete it for you. Answer by "?" when appropriate.
Please bring this completed form with you to your Preadmission Center appointment.

PERSONAL INFORMATION:

Patient Name: ______________________________

Date of Admission or Procedure: ______________________________

Person providing information: ______________________________

Relationship: ______________________________ Date: ______________

Language spoken: ❑ English ❑ Other

Is an interpreter needed: ❑ Yes ❑ No

Name and phone number of interpreter: ______________________________

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 #: ______________

REASON FOR ADMISSION (please describe):

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ALLERGIES:

❑ None ❑ Medications ❑ Latex ❑ Food ❑ Other ______________

List Allergies and Reactions:

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Patient Name: ______________________________

Current Weight: ____________ ❑ Actual ❑ Estimated

Weight 1 year ago: ____________ ❑ Height ____________

Alcohol Use: ❑ Denies ❑ Current ❑ Past

❑ Beer ❑ Liquor ❑ Wine ❑ Other: ______________________

❑ Drinks Socially ______ per day ______ per week

Tobacco Use: ❑ Denies ❑ Current ❑ Past

❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Chew

How many cigarettes do you smoke a day? ________

Do you have a cigarette within one hour of awakening? ❑ Yes ❑ No

Illicit drug use: ❑ Never ❑ past ❑ Now______________________

Are you undergoing any treatments: ❑ Not applicable

❑ Chemotherapy ❑ Radiation ❑ Peritoneal Dialysis ❑ Dialysis

❑ Other: ______________________________

Immunizations:

❑ Tetamus / Yr ________ ❑ Flu Vaccine / Yr________ ❑ Pneumonia Vaccine / Yr________

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

NAME OF MEDICATION	DOSE	FREQUENCY
HERBAL PREPARATIONS		

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

Form OR-31 (2/11)

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Patient Name: ______________________________

RESPIRATOR / LUNGS: ❑ No problem

❑ Asthma	❑ Loud Snoring	❑ Sleep Apnea
❑ Cancer ____________	❑ Pneumonia	❑ TB
❑ Chronic Bronchitis	❑ Positive TB Test	❑ Tracheotomy
❑ Chronic cough/cough with mucus	❑ Recent Cold or Flu	❑ Wheezing
❑ Emphysema	❑ Shortness of Breath	❑ Other: ____________

VASCULAR / HEART: ❑ No problem

❑ Abnormal EKG	❑ Heart Attack	❑ Palpitations
❑ Blood Clots	❑ Heart Blockage	❑ Phlebitis
❑ Cancer ____________	❑ Heart Murmur	❑ Swelling of Feet / Ankles / Legs
❑ Chest Pain	❑ High/Low Blood Pressure	❑ Valve Disorder
❑ Chest Pressure	❑ Internal Defibrillator	❑ Varicose Veins
❑ Circulation Problems	❑ Irregular Heart Beat	❑ ____________
❑ Fainting Episodes	❑ Pacemaker	

NEUROLOGICAL / BRAIN / SPINAL CORD ❑ No problem

❑ Alzheimer's	❑ Fainting	❑ Seizures
❑ Back Pain	❑ Frequent Headache	❑ Severe Headaches
❑ Cancer	❑ Memory Problems	❑ Speech Slurred
❑ Difficulty Learning	❑ Mini Stroke	❑ Stroke
❑ Difficulty Speaking	❑ Neck Pain	❑ Tingling of Arm / Leg L R
❑ Difficulty with Balance	❑ Numbness	❑ Weakness
❑ Dizziness	❑ Paralysis of Arm / Leg L R	❑ ____________

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GASTROINTESTINAL / BOWEL / DIGESTIVE: ❑ No problem

❑ Bowel Obstruction
❑ Cancer ____________
❑ Chronic Diarrhea
❑ Cirrhosis of Liver
❑ Colitis
❑ Colostomy
❑ Constipation
❑ Crohn's Disease
❑ Excessive Burping
❑ Heartburn
❑ Hemorrhoids
❑ Hepatitis
❑ Hiatal Hernia
❑ Ileoscomy
❑ Irritable Bowel
❑ Jaundice
❑ Pancreatitis
❑ Rectal Bleeding
❑ Nausea / Vomiting
❑ Ulcer
❑ ____________

MUSCULOSKELETAL: ❑ No problem

❑ Arthritis
❑ Artificial Joint(s)
❑ Cancer ____________
❑ Fracture
❑ Gout
❑ Lupus
❑ Muscle Disease
❑ Muscle Weakness
❑ Osteoporosis
❑ Pins, Rods, Internal ????
❑ Sciatica
❑ TMJ Pain or Jaw Disorder
❑ ____________

ENDOCRINE: ❑ No problem

❑ Cancer ____________
❑ Diabetes
❑ Hormone Disorder
❑ Low Blood Sugar
❑ Thyroid Disorder
❑ ____________

BLOOD: ❑ No problem

❑ Anemia
❑ Blood Transfusion
❑ Cancer ____________
❑ Easy Bruising
❑ Frequent Nosebleeds
❑ Immunosuppressed
❑ ____________

PSYCHIATRIC: ❑ No problem

❑ Anger
❑ Anxiety
❑ Dementia
❑ Depression
❑ Eating Disorder
❑ Hallucinations
❑ Manic Depression
❑ Mood Swings
❑ Schizophrenia
❑ Suicide Attempt
❑ ____________

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SKIN: ❑ No problem

❑ Bed Sore ❑ Shingles ❑ Ulcerations

❑ Non-Healing Sores ❑ Skin Cancer ❑ ____________________

❑ Rashes ❑ Skin Disorder

URINARY / REPRODUCTIVE: ❑ No problem

❑ Blood in Urine ❑ Los of Control

❑ Burning ❑ Pain

❑ Cancer ____________________ ❑ Prostate Problems (males)

❑ Difficult Urination ❑ Self Catheterization

❑ Frequent Urination ❑ Sexually Transmitted Diseases

❑ Infections ❑ Urinary Catheter (presently)

❑ Kidney Stones ❑ Ureterostomy

Females:

Last Menstrual Period: ____________________

Pregnant:

❑ Yes ❑ No ❑ Unsure

Weeks Pregnant: ____________________

Due Date: ____________________

❑ Breast Feeding

EYES / EARS / NOSE / THROAT: ❑ No problem

❑ Blind ❑ Deaf ❑ Hearing Impairment

❑ Cancer ____________________ ❑ Deviated Septum ❑ Ringing in Ears

❑ Cataracts ❑ Glasses ❑ Sinus Problems

❑ Contact Lenses ❑ Glaucoma ❑ TTY Needed

❑ Corneal Implants ❑ Hearing Aids ❑ ____________________

OPERATION PROCEDURES: ❑ None

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ANESTHESIA: ❑ No problem

- ❑ Never had Anesthesia
- ❑ You or a blood relative had unexplained fever right after surgery
- ❑ Difficult intubation, problems with airway, breathing
- ❑ Difficulty waking up from Anesthesia
- ❑ You required ventilator after surgery
- ❑ Blood relative required ventilator after surgery
- ❑ Severe nausea after surgery

DENTAL HISTORY: ❑ No problem

- ❑ Braces
- ❑ Bridges
- ❑ Broken Teeth
- ❑ Caps
- ❑ Implants
- ❑ Loose Teeth
- ❑ ______________________________

- ❑ Dentures:
- ❑ Upper
  - ❑ Full ❑ Partial
- ❑ Lower
  - ❑ Full ❑ Partial

NUTRITION: ❑ No problem

Special Diet: ❑ No restrictions

❑ Cardiac	❑ Diabetic	❑ Kosher	❑ Thick It
❑ Chopped / Soft	❑ Feeding Tube	❑ Low Salt Diet	❑ Vegetarian
❑ Cultural-Specific Diet	❑ Fluid Restriction	❑ Renal	

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

If yes, how much weight have you lost?

- ❑ 1 - 5 lbs (1 point)
- ❑ 6 - 10 lbs (2 points)
- ❑ 11 - 15 lbs (3 points)
- ❑ > 15 lbs (4 points)
- ❑ Unsure (2 points)