

PLACE LABEL HERE

Pre-Admission Interview

Ph# _____

Name _____ D.O.B. _____ Ph# _____

Procedure _____ SX date _____ Ph# _____

Surgeon _____ Emergency contact name/# _____

Historian _____ Transportation _____

Primary Language English Spanish Creole Other _____ Translator _____

Learning Barriers Physical Language Barrier Slurred speech Reading ability Learning assistance Patient Family Other _____

Primary care physician _____ Ph# _____ last visit _____

Cardiologist _____ Ph# _____ last visit _____

Specialist _____ Ph# _____ last visit _____

Height _____ ft. _____ in. Weight _____ lbs. BMI _____ First time at SCW? Y N Date _____ Chart# _____

Neurological/Sensory _____

- Denies history
- Vision Impairment
 - Glasses Contact Lenses
- Glaucoma
- Hearing loss/ Deaf/ Hard of hearing
 - Wears hearing aids R L
- Motion sickness
- Fibromyalgia/Migraines
- Seizures
 - Last seizures date _____
- Tremors
- Stroke/CVA/TIA
- Paralysis
- Neuromuscular weakness
 - Type _____
- Parkinson's
- Dementia
- Changes in short term memory

- High blood pressure or takes blood pressure medications
- Irregular heart beats
- Arrhythmias
- Pacer/AICD (defibrillator)
 - Date last checked _____
 - Model _____
- Mitral valve prolapse
- Valve replacement
- Heart Murmurs
- Congenital Abnormalities
 - Hole in heart
- Unable to walk a flight of stairs?
- Unable to walk several steps?
- Bleeding clotting problems
- Sickle cell disease
 - Last crisis date _____
- DVT
- Phlebitis
- Neuropathy
- Anemia
- Jaundice
- Cirrhosis of the liver
- Recent EKG Date _____
- Recent stress test Date _____
- Other cardiac tests

- Heart Stents *How many?* _____
 - Date of stents _____
- Takes blood thinners/ anticoagulants?
 - Coumadin Aspirin
 - Plavix Pradaxa
 - Other _____
- Physician has instructed to stop taking blood thinners before surgery.

Be sure to discuss with your physician when to restart your blood thinner medication
- Additional labs or tests taken
 - Blood Date _____
 - Urine Date _____
 - X-rays Date _____
 - Other _____

Respiratory _____

- Denies History
- Asthma/Bronchitis
 - Triggers _____
 - Takes medication for Asthma
 - More than 2 asthma attacks a week
 - Uses steroid medication
 - Uses Inhaler
 - Bring inhalers on day of surgery

Cardiovascular/Hematology _____

- Denies History
- Chest Pain/Angina
- Feeling of pressure
- Heart Attack Date _____

- COPD/Emphysema
- Use of Oxygen at home
- Pneumonia
- Cold or Flu (last 6 weeks)
 - Fever
 - Productive Cough
 - Runny nose
- Sinus Infections
- Use of C-PAP at home
 - Bring C-PAP on day of surgery
- Difficulty lying flat
- Wake up tired?
- Snores and is heard through closed doors
- Sleep apnea study
- Other _____

Women's Health _____

- Denies History N/A
- Discharge/Bleeding
- Hysterectomy *Date* _____
- Tubal Ligation *Date* _____
 - Last menstrual cycle _____
- Pregnancies C-Sections
- HCG Diet
- Other _____

Pediatrics (Child < 16) _____

- Full term N/A
- Pre-mature birth
- Post-conceptual age is more than 60 wks
 - Weeks gestation _____
 - + Current age _____
 - Post-conceptual age = _____
- Congenital abnormalities
 - Hole in heart
- Any syndromes
- Syndrome* _____
 - If premature
 - Stroke
 - Bleeding in brain
 - Intraventricular Hemorrhage
 - Child has been on apnea monitoring
- RDS (Respiratory Distress Syndrome)
- Cerebral Palsy
- Muscle Weakness
- Difficulty walking
- Developmental Delays

- Immunized recently *Date* _____
 - Which* _____
- Delay Immunizations until several days after surgery, or postpone elective surgery several days after Immunizations

Cancer _____

- Denies History
- Type* _____
- Year* _____ *TX* _____
- Chemotherapy

Gastrointestinal _____

- Denies History
- Liver Disease
- Weight gain/loss
- GERD/Reflux
- Ulcers
- Hiatal Hernia
- Colostomy/Ileostomy
- HX of Recent Nausea & Vomiting

Genitourinary/Renal _____

- Denies History
- Incontinence
- Kidney Disease
- Stones
- Prostate Problems
- HX Flomax use
- Dialysis *Date* _____
- Access port
- UTI in last 2 months
- Other _____

Musculoskeletal/Mobility _____

- Denies History
- Muscle Disorders
- Arthritis Osteo Rheumatoid
- Pain During movement
- Difficulty with ADLS
- Difficulty Walking
- Cervical Problems
- Back/Disc Problems
- TMJ/Jaw stiffness
- Numbness/weakness
 - Arms L R Legs L R
- Uses: Wheelchair Cane
 - Walker Scooter
- Other _____

Fall Risk _____

- Denies History
- HX of falls
- Gait Unsteady
- Has fallen in the past 3 months, dizzy or unsteady on your feet?
- Chronic Pain History
- Location* _____
 - Controlled

Endocrine _____

- Denies History
- Diabetes
 - Type 1/IDDM
 - Type 2/NIDDM
 - Diet controlled Medication
- Blood Sugar _____ *MG/DL norm 70-110*
- Thyroid Disease
- Other _____

Infection Disease _____

- Denies History
- HIV/AIDS
- Hepatitis B or C
- C-Difficile
- Tuberculosis
- MRSA
- CJD (Creutzfeldt – Jacob)
- HX* _____
- TX* _____

Skin Problems _____

- Denies history
- Rashes
- Molluscum Contagiosum
- Shingles
- HX* _____
- TX* _____

- Wounds
- HX of bruising
- Delicate skin/Skin Breakdown
- Difficult IV placement or starts
- Other _____

Social History _____

- Smoke
 - Tobacco use in the past year
 - Packs per/day? _____ Years _____
 - When did you quit? _____
- Alcohol
- Recreational Drugs

Do you have any religious or cultural practices that are important to you that may alter your care or education? Y N

Name _____

SX Date _____

PLACE LABEL HERE

Behavioral Health _____

- Denies History
- Anxiety
- Depression
- Emotional Issues
- Bipolar
- Schizophrenia
- Claustrophobia
- Other _____

Support Services _____

- Lives alone
- Lives with _____

Who is your Primary Caregiver?

Do you have a responsible adult to stay or check on you after surgery? Y N

Comments _____

Arrangements _____

- Transportation Reservation

Do you have an advance directive?

- Y N

Do you have a Medical Power of Attorney?

- Y N

If so, bring a copy along

- To Obtain HealthCare Proxy

Past Hospitalizations & Surgeries _____

- Denies History

Allergies & Reactions _____

Medication allergy Y NKDA

List medications and reactions

medication	reaction
medication	reaction
medication	reaction
medication	reaction
medication	reaction

medication	reaction
medication	reaction
medication	reaction
medication	reaction

Latex allergy Y N

(Include separate Latex Questionnaire)

Food allergies Y N

- Soy Shellfish Eggs

food	reaction
food	reaction
food	reaction
food	reaction

Contrast Dye/Iodine Y N

- Other _____

Anesthesia _____

Patient ever had anesthesia Y N

Anesthesia Reaction Y N

Family reaction Y N

Malignant Hyperthermia Y N

NURSING DX: Potential anxiety related to knowledge deficit.

Outcome Goal:

- Demonstrated decreased anxiety & understanding of preoperative process.
- Demonstrated eagerness to learn, asked questions & denies educational needs

Plan & Implementation:

- Sequence of events explained, preoperative instructions given, patient concerns communicated.

Pre-Op Instructions Given _____

- Wear attire loose comfortable clothing with buttons or zippers.
- For Cataract SX, slip on shoes, no laces
- Bring Photo ID/ Insurance card.
- No valuables/ jewelry/ piercings.
- No make-up, lotion on face or hands.
- Bring Mobility Assistance.
- Insure wound care supplies are at home.
- Get necessary prescriptions filled. prior to your procedure day.

- Get necessary prescription from physician for:

- Crutches Arm sling
- Knee/leg immobilizer
- Arm immobilizer Cast boot

- Bring copy of Power of attorney documents.

- Medications taken morning of procedure with sip of water only.

- Blood Pressure Medications

- Seizure Medications

- Bring Inhalers, if applicable

- Hold diabetic medications

- NPO after midnight and am of surgery

- Bring a list of all medications being taken or bring all the medication bottles.

Pediatrics (less than 1 year) _____

- Well hydrate day before up to midnight
- 2 hrs. prior to arrival – 4 to 6 oz. water or pedialyte.
- 4 hrs. prior to arrival – 4 to 6 oz. breast milk
- 6 hrs. prior to arrival – 4 to 6 oz. formula.

Bring on day of surgery

- Water bottle
- Infant Supplies
- If child is adopted, bring copy of adoption documents.
- Bring change of clothes and diapers in case of any accidents.

Pediatrics (1-5 years) _____

- Well hydrate day before until midnight
- 2 hrs. prior to arrival – 4 to 6 oz. water or pedialyte.

Interviewer

Signature _____

Date/time _____

Name _____

SX Date _____

PLACE LABEL HERE

