

Please Place Patient Label Here
DO NOT COVER BARCODE



12500

**Personal Medical History
Pre-Admission Testing**

STAFF USE ONLY		
Ht: _____	Wt: _____ kg	Rm #:
O ₂ : _____	BP: _____	Tech:
P: _____		RN/C.A.:

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____

Family Doctor: _____ Doctor's Phone: _____ Last Seen: _____

Specialty Doctor (Heart, Lung, Kidney, etc.) _____ Last Seen: _____

Advanced Health Directive: (check what you have AND please bring a COPY to PAT)

- Health Care Proxy Living Wills DNR

Emergency Contact Person (name, relation, and phone #) _____

Past Medical History		Patient to Complete Past Medical History	Staff Use Only ROS	
Constitutional:	Weight Stable	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS	
	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS	
	Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS	
	Night Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS	
	Unusual Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS	
HEENT:	Eye Problems	Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
		Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
		Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
		Artificial Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ear Problems	Contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Lens after Cataract Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
		Ringling	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
		Hearing Aids <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Arthritis:	Osteo	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Rheumatoid	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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Respiratory:	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	CPAP	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Oxygen	<input type="checkbox"/> _____ liters	
	Pneumonia within 6 weeks	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Bronchitis within 6 weeks	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Sputum Production	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
	Hemoptysis (Cough up Blood)	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
	Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
Cancer:	Where: _____		
	When: _____		
	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Port	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Circulation Problems:	Legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Endocrine:	Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
	When diagnosed? _____		
	On Insulin	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	On Insulin Pump	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you test?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Average A.M. Blood Sugar		
Heart Disease:	Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
	Heart Attack (Myocardial Infarction)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Angioplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Heart Catheterization	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Stent	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Atrial Fibrillation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Pacemaker / ICD (Defibrillator)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	ICD (Defibrillator)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Leaky Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
	Shortness of Breath on Exertion or at rest	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
Chest Pain / Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS	

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GI:	Stomach	Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Hiatal Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Liver	Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Bowel	Yellowing of Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Do you have normal bowel habits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
		Frequency	_____	
		What do you take to stay regular?	_____	
		Crohns	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Polyps	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Diverticulitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Colostomy / Ileostomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Hematochezia (Blood in Stool)	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
		Hematemesis (Vomiting Blood)	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
	Change in Bowel Habits	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS	
Last colonoscopy (year) _____				
GU:	Kidney	Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Decreased Function	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		If yes, where?	_____	
	Bladder	When?	_____	
		Prostate	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Last prostate exam (year) _____		
		Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Growth	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Do you have normal urinary habits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Dropped Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Do you have a catheter at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Frequency at night	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
		Urgency	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
		Dysuria (painful or difficult urination)	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
GYN:	Last pap test (year) _____			
	Last mammogram (year) _____			
	Last menstrual period (date) _____			
Neurologic:	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Tremors	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	CVA (stroke)	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS	
	TIA (mini strokes)	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS	
Extremities / Musculoskeletal:	Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Muscle Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS	
	Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS	
	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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Psychiatric:	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Panic Attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Skin Problems:	Any Rash or Open Areas	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Steroid Therapy:	Prednisone Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hematologic:	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS
	Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	ROS

Please List: Serious Injuries, accidents, aneurysms, conditions, Sickle Cell, T.B., other problems

Past Surgical History (If you have a list of your surgeries, please attach here.)

List ALL Surgeries with Approximate Dates:

Any PROBLEMS you or your family had with Anesthesia? (Describe) _____

Family History (list SERIOUS illnesses)

Father: _____

Mother: _____

Siblings: _____

Children: _____

Have you ever been on isolation in the hospital?

Yes No

Why? _____

When? _____

Substance Abuse/Social History

Do you Smoke now? Yes No

Did you smoke in the past? Yes No

How many years? _____

When Quit _____

How many Packs Per Day? _____

Do you drink alcohol? Yes No

What and how much? _____

Do you use recreational drugs? Yes No

What and frequency? _____

Have you ever been emotionally **ABUSED** by someone close to you? Yes No

Have you ever been physically **ABUSED** by someone close to you? Yes No

Who _____ When _____

Have you experienced any RECENT stress OTHER than upcoming surgery? Yes No

Describe _____

Do you feel you need any counseling at present? Yes No

DO you have any CHRONIC (over 6 months) pain? Yes No

Where _____ For how long _____

Do you have: Dentures Yes No Chipped/cracked teeth Yes No

Loose Caps/crowns Yes No TMJ (Jaw pain) Yes No

Loose Teeth Yes No Yes No

Braces Yes No Yes No

Do you have any cultural or religious practices that need to be part of your care? Yes No

Do you have any religious or other objections to blood products? Yes No

Do you have any Discharge Concerns? Yes No

Do you have any Home Services at this time? Home Aids Nurses Meals on Wheels
 Lifeline Oxygen delivery Other

Do you have stairs? Yes No

Do you live alone? Yes No

Who will assist you at home? _____

This Personal Medical/History has been completed to the best of my knowledge:

Patient's Signature: _____

If other than patient Signature: _____ Relation: _____

Reviewed by (Staff): _____ Date: _____