INSTRUCTIONS TO THE PATIENT: Please answer all questions below as completely and honestly as possible.
Please indicate your answer to each question by a check (✓).

INSTRUCTIONS TO RN: Review patient information and sign oil reverse side.

☐ If patient data form completed in ER. initial that you have reviewed here:_____

➔ go on to assessment oil reverse side.

MEDICAL HISTORY PER PATIENT / PATIENT REPRESENTATIVE

Reason for Admission: _____ Date: _____ Time: _____

*Have you had any of the following in the past few days?

☐ Fever ☐ Sore Throat ☐ Difficulty Breathing ☐ Chest Pain ☐ Nausea ☐ Other:
☐ Vomiting ☐ Headache ☐ Cough ☐ Diarrhea ☐ Belly Pain _____
☐ Bleeding ☐ Problems urinating ☐ Leg Swelling ☐ Fainting ☐ Leg cramping _____

Pain Intensity Scale: 0 1 2 3 4 5 6 7 8 9 10 (most severe)

Medical History - Have you ever had any of the following?

☐ Heart Disease ☐ Shortness of breath ☐ High Blood Pressure ☐ Eye Disease
☐ Liver problems ☐ Chest Pain ☐ Asthma ☐ Stroke
☐ Seizures ☐ Leg Cramping ☐ Lung disease ☐ Excess Bleeding
☐ Blood Clots ☐ Kidney Problems ☐ Diabetes ☐ Transfusions
☐ Psychiatric Problems ☐ Back Problems ☐ Ulcers
☐ Cancer_____ ☐ Arthritis ☐ Emphysema
☐ High Cholesterol ☐ Hay Fever

☐ ***History of Infectious Disease***
☐ *ORSA* ☐ *Positive HIV test*
☐ *VRE* ☐ *Tuberculosis Hx*
☐ *MRSA* ☐ *Hepatitis*
☐ *VDISM* ☐ *Night Sweats Productive cough weight loss*
☐ *Other* _____

Are you pregnant now? ☐ Yes* ☐ No Are you breast feeding? ☐ Yes* ☐ No
*Do you have any difficulty performing self-care? ☐ Yes ☐ No
*Difficult swallowing / increase choking? ☐ Yes ☐ No

Height _____ Weight _____
*Have you had any unexpected weight change? ☐ Yes ☐ No
*Inability to eat regular diet greater than 7 days? ☐ Yes ☐ No

Do you have any special religious/cultural background/language preferences? ☐ Yes _____ ☐ No

Allergies: Please list your allergies to medication and the type of reaction.

☐ None ☐ Tape ☐ Iodine ☐ *Latex ☐ Shellfish ☐ IV Dye

_____
_____

Surgeries: Please list operations and approximate year done.

_____
_____
_____

***Anesthesia / Sedation Problems:** Please describe:

_____
_____

Medications: Please list all medications and supplements including ***herbal preparations or diet aids.**

Medication	Reason	Dose	Frequency

Have you ever smoked? ☐ Yes ☐ No If 'Yes', for how long and when did you quit?_____

Habits: ☐ Cigarettes ☐ Cigars _____ per day ☐ Alcohol ➔ ☐ Occasional ☐ Heavy ☐ Recreational Drugs

Advanced Directive: ☐ Yes ☐ Copy on file @ LRRMC.
☐ Instructed to provide from whom:_____
☐ No Is assistance formulating Advance Directives requested? ☐ No ☐ *Yes ◆ CSW

Transportation Home/Responsible adult available to you the first 24 hours at home.

Name: _____ Phone #: _____ ☐ Call ☐ Here

Patient Signature: _____

To be Completed by Nurse Admitting Patient

* Physician Notified ☐

* Suspected Neglect/Abuse
☐ Self
☐ Others
Notify CSW

* Pharmacy Notified ☐

*PT/OT consult? Notify MD

*Nutrition consult? Dietitian Notified ☐

*OR Notified ☐

*Anesthesia Notified ☐

*Anesthesia Notified ☐

LOS ROBLES HOSPITAL & MEDICAL CENTER

OUT-PATIENT PRE-SURGICAL AND PRE-PROCEDURAL ASSESSMENT