HPI COMMUNITY HOSPITAL INTEGRIS Network

HPI NORTHWEST SURGICAL HOSPITAL INTEGRIS Network

PATIENT HISTORY QUESTIONNAIRE

Primary Care Doctor: ________________ (Name) ________________ (Phone Number) ❑ **N/A** **Cardiologist:** ________________ (Name) ________________ (Phone Number) ❑ **N/A**

Pharmacy: ________________________________ **Pharmacy Phone#** ________________________________

Best phone number to reach you: ____________________ **Alternate Phone #** ________________________________

Social History: ❑ Married ❑ Single ❑ Divorced ❑ Widow(er) ❑ Separated ❑ Lives Alone ❑ At Home ❑ Assisted Living ❑ Nursing Home

Have You Had:

1. Heart disease, stents, bypass, MI, chest pain, irreg. heartbeat, PVD........ Yes ☐ No ☐
2. Abnormal EKG........ Yes ☐ No ☐
3. Congestive Heart Failure........ Yes ☐ No ☐
4. Pacemaker/Implanted Defibrillator........ Yes ☐ No ☐
5. Heart Valve Replacement........ Yes ☐ No ☐
6. High Blood Pressure/Low Blood Pressure........ Yes ☐ No ☐
7. Swelling Ankles/Feet........ Yes ☐ No ☐
8. Asthma........ Yes ☐ No ☐
9. Bronchitis/Emphysema........ Yes ☐ No ☐
10. Abnormal Chest X-ray........ Yes ☐ No ☐
11. Tuberculosis........ Yes ☐ No ☐
12. Oxygen at Home........ Yes ☐ No ☐
13. Sleep Apnea History........ Yes ☐ No ☐
14. Use Assistive Devices (CPAP/NPPV) (circle)........ Yes ☐ No ☐
15. Stroke or TIA........ Yes ☐ No ☐
16. Paralysis (R) (L)........ Yes ☐ No ☐
17. Slurred Speech........ Yes ☐ No ☐
18. Difficulty Swallowing........ Yes ☐ No ☐
19. Digestive Problems (GERD)........ Yes ☐ No ☐
20. Blood Vessel Disease (Phlebitis, etc.)........ Yes ☐ No ☐
21. Abnormal Bleeding Tendencies (Bone marrow disease, platelet abnormality, bleeding disorder, Family history of bleeding disorder, blood clots)........ Yes ☐ No ☐
22. Are you on or have you ever had blood thinners........ Yes ☐ No ☐
23. Blood Disease (Anemia)........ Yes ☐ No ☐
24. Seizures/Epilepsy........ Yes ☐ No ☐
25. Numbness of Arms and/or Legs........ Yes ☐ No ☐
26. Muscle Weakness........ Yes ☐ No ☐
27. Fractured: ❑ Facial Bones ❑ Neck ❑ Back........ Yes ☐ No ☐
28. Joint Replacements........ Yes ☐ No ☐
29. Back Trouble........ Yes ☐ No ☐
30. Glaucoma/Cataracts........ Yes ☐ No ☐
31. Mononucleosis........ Yes ☐ No ☐
32. Hepatitis A, B, or C/Cirrhosis/Liver Disease........ Yes ☐ No ☐
33. Kidney Disease (ESRD, CRI)/Dialysis/ Schedule________________........ Yes ☐ No ☐
34. Diabetes........ Yes ☐ No ☐
35. Sickle Cell Disease........ Yes ☐ No ☐
36. Positive HIV / AIDS Blood Test........ Yes ☐ No ☐
37. Cancer / Location ____________________........ Yes ☐ No ☐
38. Chemo or radiation within last 3 months........ Yes ☐ No ☐
39. Arthritis........ Yes ☐ No ☐
40. Thyroid Problems........ Yes ☐ No ☐
41. Motion Sickness........ Yes ☐ No ☐
42. Smoke / Pkg/day______ How long? ______........ Yes ☐ No ☐
    Date quit _______________
43. Alcohol Use/How often?__________________ Yes ☐ No ☐
44. Recreational Drug Use (Street Drugs)........ Yes ☐ No ☐
45. Immunizations: ❑ Tetanus ❑ Hep A ❑ Hep B ❑ Flu Shot__________ (date rec'd) ❑ Pneumonia___________ (date rec'd)
46. Are you pregnant / lactating (circle)........ Yes ☐ No ☐
    Last Menstrual Period ____________________
47. Any body piercing?........ Yes ☐ No ☐
48. Any false or loose teeth, bridges?(circle)........ Yes ☐ No ☐
49. Wear contact lenses / glasses? (circle)........ Yes ☐ No ☐
50. Have you donated blood to yourself?........ Yes ☐ No ☐
51. Have you ever had a blood transfusion?........ Yes ☐ No ☐
52. Do you object to a blood transfusion?........ Yes ☐ No ☐
53. Any cuts, bruises, sores or rashes........ Yes ☐ No ☐
54. Any reaction to latex, tape, gloves or elastic........ Yes ☐ No ☐
55. Date of last anesthetic____________________________
56. Any abnormal reactions to anesthetics?........ Yes ☐ No ☐
57. Relative with any abnormal reactions to anesthetics?........ Yes ☐ No ☐
58. Any other medical illnesses__________________________
    ____
    ____
    ____

Weight (pounds) ____________________ **Height** __________ **ft** __________ **in**

Please Continue On Second Page

Patient Label

Patient Name: ______________________

DOB: ______________________

SX-111	Ver. #: 9
Rev: 9/23/19	Add inquiry of pain, phone #'s

List previous surgical/invasive procedures (type and date):

1. ____________________ **4.** ____________________
2. ____________________ **5.** ____________________
3. ____________________ **6.** ____________________

List any medications currently taking: ☐ **No home medications**

(Please include any over the counter medications and/or supplements)

1. ____________ dose/freq____________last date/time taken__________
2. ____________ dose/freq____________last date/time taken__________
3. ____________ dose/freq____________last date/time taken__________
4. ____________ dose/freq____________last date/time taken__________
5. ____________ dose/freq____________last date/time taken__________
6. ____________ dose/freq____________last date/time taken__________
7. ____________ dose/freq____________last date/time taken__________
8. ____________ dose/freq____________last date/time taken__________
9. ____________ dose/freq____________last date/time taken__________
10. ____________ dose/freq____________last date/time taken__________
11. ____________ dose/freq____________last date/time taken__________
12. ____________ dose/freq____________last date/time taken__________

Allergies (drug and food) Please describe reaction for each: ☐ **No Known Allergies**

1. __________ Reaction__________ **5.** __________ Reaction__________
2. __________ Reaction__________ **6.** __________ Reaction__________
3. __________ Reaction__________ **7.** __________ Reaction__________
4. __________ Reaction__________ **8.** __________ Reaction __________

Patient Signature______________________________**Date**__________

PATIENTS-DO NOT WRITE BELOW THIS SECTION

PAT Staff Use Only: Weight: ________lbs. ________kg Height: ________ BMI: ________ MET________

Education Given: ☐Chlorahexadine ☐ Medication Discontinuation Instructions ☐ NPO Instruct. ☐Med Rec Sheet

PRE-OP Staff Use Only: Weight: ________lbs. ________kg Height: ________BMI: ________ NPO since: ________

FSBS: ________ BP: ______/______ P: ________ R: ________ O2 Sat: ________ Temp: ________

PAT Nurse Review Signature:______________________**Date:**__________**Time:**__________
Pre-Op RN Review Signature:______________________**Date:**__________**Time:**__________

Anesthesia Evaluation (For Anesthesia Use Only)

General Appearance:______________________ ☐ Obesity – BMI >40
Sensorium: ☐ AA &O ☐ Drowsy ☐ Confused Age Appropriate:__________
Head & Neck: ☐ WNL ______________________ Mallampati: 1 2 3 4
Cardiovascular: ☐ RRR ☐ Murmur ______________ Chest: ☐BS CTA Bilateral ______________
Abdomen: ☐ WNL ☐ Distended ______________ Extremities & Back: ☐ WNL ______________
Skin: ☐p/w/d ☐Intact ☐ Pale ☐Diaphoretic __________ IV Infusion: ☐ Patent Site: __________
Anesthesia Plan: ☐ General ☐Spinal ☐ Epid ☐Regional ☐ MAC/L. Standby ASA: 1 2 3 4 5 E

The Patient History Questionnaire was reviewed and discussed with patient (or representative) during the pre-operative assessment. Impression and plan, including the type of medication to be administered, as well as the alternatives, risks, and benefits of delivery of anesthesia have been discussed with the patient (or representative) who understands and accepts and gives consent.

Date: __________ Time: __________ Anesthesia Evaluator: ______________________ MD DO CRNA

Please Continue on Third Page

Patient Label

Patient Name: ______________

DOB: ______________

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Patient History Questionnaire

Are you experiencing pain? ☐ **Yes** ☐ **No**

If You Experience Pain, Please Describe the Following:

Location: ____________________

Quality:(dull, sharp aching)____

Severity (mild, mod or severe) ____

Timing: (When does this happen?)____

Duration: (How long does the pain last?) ______________________________________

Mod Factors(What makes it better?) ____

Associated Signs and Symptoms: __________________________

1st Degree Relative Health History:

Family History of:	Family Member (Father, Mother, Brother, Sister)
☐ Cancer	____________
Type: ____________	____________
☐ Heart Disease	____________
☐ Lung/Respiratory Disease	____________
☐ Stroke	____________
☐ Kidney Disease	____________
☐ Diabetes	____________
☐ High Cholesterol	____________
☐ High Blood Pressure	____________

Mother

☐ Alive, Age____

☐ Deceased, Age ____ of ____________

Father

☐ Alive, Age____

☐ Deceased, Age ____ of ____________

Brother(s)

☐ Alive, Age____

☐ Deceased, Age ____ of ____________

☐ Alive, Age____

☐ Deceased, Age ____ of ____________

☐ Alive, Age____

☐ Deceased, Age ____ of ____________

☐ Alive, Age____

☐ Deceased, Age ____ of ____________

☐ Alive, Age____

☐ Deceased, Age ____ of ____________

Sister(s)

☐ Alive, Age____

☐ Deceased, Age ____ of ____________

☐ Alive, Age____

☐ Deceased, Age ____ of ____________

☐ Alive, Age____

☐ Deceased, Age ____ of ____________

☐ Alive, Age____

☐ Deceased, Age ____ of ____________

☐ Alive, Age____

☐ Deceased, Age ____ of ____________

______________________________ _____/_____/_________ __________

Patient Signature Date Time

______________________________ _____/_____/_________ __________

Nurse Date Time

Community Hospital South Campus
Pre-Admission Clinic
3100 S.W. 89th Street
Oklahoma City, OK 73159
Phone: (405) 605-2660
Fax: (405) 605-2661

Patient Label

Patient Name: ____________________

DOB: ____________________

Community Hospital North Campus
Pre-Admission Clinic
9800 Broadway Extension
Oklahoma City, OK 73114
Phone: (405) 605-2660
Fax: (405) 605-2661

SX-111	Ver #9
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Metabolic Activity Table

MET Scoring

Can patient do the following without stopping to rest:

MET

1) Eat, dress yourself
2) Walk indoors around the house
3) Walk 2 blocks on level ground
4) Climb one flight of stairs without stopping or walk up a hill
5) Run a short distance
6) Do moderate extended work around the house such as vacuuming, sweeping, and dusting
7) Do heavy work around the house such as scrubbing floors or moving heavy furniture
8) Do yard work such as raking leaves, weed-eating, or pushing a power mower.
9) Participate in moderate recreational activities such as doubles tennis, dancing, bowling, walking the golf course.
10) Participate in strenuous sports such as swimming, singles tennis, football, basketball, or skiing

Is the limitation due to pain in extremities? ☐ Yes ☐ No

Does any activity listed above cause: ☐ Shortness of breath ☐ Chest tightness ☐ Chest Pain

_________________________________ ____/____/________ _________

Nurse Signature Date Time

Community Hospital South Campus
Pre-Admission Clinic
3100 S.W. 89th Street
Oklahoma City, OK 73159
Phone: (405) 692-6600
Fax: (405) 692-6601

Patient Label

Patient Name: ____________________

DOB: ____________________

Community Hospital North Campus
Pre-Admission Clinic
9800 Broadway Extension
Oklahoma City, OK 73114
Phone: (405) 419-5926
Fax: (405) 419-5931