COFFEE REGIONAL MEDICAL CENTER

AMBULATORY SURGERY UNIT
LAB & DIAGNOSTIC TESTS

3PO

Pre−Surgery Diagnosis:_____Scheduled Procedure:_____

Date of Procedure:_____Allergies:_____Precertification #:_____

❑ No Lab Tests Required

❑ Anesthesiology Consultation(Patients with Medical or Surgical issues)

❑ Hgb/Hct
❑ CBC without diff
❑ CBC w/diff
❑ PT
❑ PTT
❑ CMP
❑ BMP
❑ Blood Glucose
❑ FSBS Day of Surgery
❑ Uric Acid
❑ Urinalysis w/ Micro

❑ Urine HCG
❑ Serum Pregnancy
❑ Quant. HCG
❑ HBsAg
❑ Sickle Cell Screening
❑ Amylase
❑ Lipase
❑ Hepatic Panel
❑ COVID Swab
❑ Other Lab
❑ MRSA Screen

❑ Type and Screen
❑ Crossmatch ___# units PRBCs
❑ Crossmatch ___# units autologous Blood
❑ Other blood products_____
❑ CXR
❑ KUB
❑ Other X−ray_____
❑ Ultrasound _____
❑ 12 lead ECG
❑ PFT
❑ Urine for nicotine day of surgery (EGD and Lap Gastric Sleeve)

Blood for pre−transfusion testing must be drawn within 48 hours of surgery. Typed and Screened blood can only be held 48 hours.

Pre−Surgery Orders ❑ **OPS (Outpatient Surgery)** ❑ **IP (Inpatient)** ❑ **Unknown Length of Stay**

Vital Signs: ❑ Per Protocol ❑ Other _____

Diet: ❑ NPO ❑ NPO after _____

❑ PRP Draw in ASU

❑ LR at KVO or ❑ 100ml/hr ❑ 200ml/hr ❑ _____ml/hr
❑ NS at KVO or ❑ 100ml/hr ❑ 200ml/hr ❑ _____ml/hr
❑ NS (500ml bag) at KVO via microdrip tubing for renal patient

Pre Op Antibotics:

❑ Pre−Op Antibiotic in ASU/OR holding area_____

❑ Bacterial Endocarditis Prophylaxis:_____❑ Consult Pharmacy/Anesthesia

❑ Ancef 2gm IVPB x 1 on call to OR (Start within 60 min of incision) **for pt weight < 120kg**

❑ Ancef 3gm IVPB x 1 on call to OR (Start within 60 min of incision) **for pt weight > 120kg**

If allergic to PCN/B Lactam Allergy OR Patient at increased risk for infection.

❑ Vancomycin 1gm IVPB x 1 on call to OR (Start within 120 min of incision) **Pharmacy to renal dose.for pt weight < 70 KG**

❑ Vancomycin 15mg/kg IVPB x 1 on call to OR (Start within 120 min of incision) **Pharmacy to renal dose.for pt weight ≥ 70 KG**

OR

❑ Cleocin 900mg IVPB x 1 on call to OR (Start within 30 min of incision)

******Pediatric Patient Pre Op Antibotics******

❑ Ancef weight based per Pharmacy on call to OR (Start within 60 min of incision)

❑ If allergic to Ancef notify MD for alternative.

❑ Other: _____

PO_9100_EFR
Rev. 11/08/2022

COFFEE REGIONAL MEDICAL CENTER

AMBULATORY SURGERY UNIT
LAB & DIAGNOSTIC TESTS

Pre Op Medications:

- ❑ Heparin 5,000 Units SubQ
- ❑ Acetaminophen (Tylenol) suppository by weight in ASU/OR 15mg/kg (Max 650mg)
- ❑ Acetaminophen (Ofirmev) 1000 mg IVPB on call to OR
- ❑ Ibuprofen (Caldolor) 800 mg IVPB (on−call to OR)
- ❑ Ketorolac (Toradol) 30 mg IVP x 1 (on−call to OR)
- ❑ Gabapentin 300 mg PO x 1 pre−op
- ❑ Scopolamine Patch 1.5 mg
- ❑ Other _____

❑ Tranexamic Acid 1 gram IV on call to OR
- ❑ Before Incision
- ❑ After Incision

❑ Tranexamic Acid weight based 15 mg/kg IV on call to the OR.
❑ Consult Pharmacy for PediatricTranexamic Acid IV Dose.
❑ Nozin 1 pre op application of 2 ampules −swab each nostril with each ampule within 1 hour prior to surgery.

Consults:

- ❑ OT/PT Consult
- ❑ Care Management Consult

Consult Anesthesia for post−op pain block

❑ Yes ❑ No (Type of block) _____

Preparation:

- ❑ Incentive Spirometry: Instructions/pre−admit
- ❑ Thigh / Knee High TED hose
- ❑ Sequential Compression Device applied and turned on in OR
- ❑ Patient Education

Minimum Testing Guidelines (Anesthesia Service): These guidelines are suggested minimums. They are not replacement for medical judgment, and the patient's medical history and/or the proposed surgical procedure may indicate additional laboratory or diagnostic testing.
No pre−operative laboratory testing is required for asymptomatic patients without significant medical problems who are less than 40 years of age.
ECG: Males aged 40 and above require an ECG. Females aged 50 and above require ECG
Pregnancy Test: A pregnancy test is required for all menstruating females, unless not indicated due to sterility. Serum HCG if blood is drawn for other tests, otherwise it will be a urine HCG.
Labs: CBC and BMP are required for patients age 65 and older. BMP is required for diabetic, renal and/or hypertensive patients. FSBS is required day of surgery in diabetic patients, except in patient who have a BMP done day of surgery.
Copies: A copy of a CXR and/or ECG completed in the past 6 months is sufficient in the absence of a change in the patient's health status.
A copy of lab work completed in the past 30 days is sufficient in the absence of renal disease. Renal patients must have a K+ completed after their last dialysis treatment before the date of surgery.
IVF: Every patient over age 10 is required to have an IV of LR at KVO rate. Renal patients must have NS at KVO rate

_____ Physician Signature

_____ Date / Time

COFFEE REGIONAL MEDICAL CENTER

NURSING/ANESTHESIA PATIENT HISTORY QUESTIONNAIRE

3OR

SURGERY:_____ DATE OF SURGERY:_____

Height_____ Weight_____ Marital Status_____ V/S: T_____ P_____ R_____BP_____SpO2_____

1. Please list the operations you have had in your life, including: Dates (month/year), Doctor, Hospital:

   Organ Transplant? ❑ Yes ❑ No Which organ:_____
2. Please list any medical conditions you have or have had (high blood pressure, diabetes, heart attack, etc.)

3. Are you allergic to latex? ❑ Yes ❑ No Are you allergic to any food, medications, or other (specify what and type of reaction)?

4. Have you or anyone in your family ever had a reaction to a local or general anesthetic? ❑ Yes ❑ No

5. Have you ever been diagnosed with cancer? (specify if current or past) ❑ Yes ❑ No

6. Do you smoke? ❑ Yes ❑ No How many packs per day?_____For how many years? _____
   Have you recently quit smoking? ❑ Yes ❑ No How long ago & for how long have you quit?_____
   Do you chew tobacco / snuff? ❑ Yes ❑ No Do you use "street drugs"? ❑ Yes ❑ No
   If so, explain_____ How much beer, wine, or liquor do you drink per day? _____

7. Have you currently or in the past been treated for a mental / emotional condition? ❑ Yes ❑ No

8. Have you had a chest cold or chest infection in the last month? ❑ Yes ❑ No
   Do you have chronic bronchitis, asthma, COPD, emphysema, or sleep apnea? ❑ Yes ❑ No
   Do you take medicine for breathing or use a CPAP / BiPAP machine? ❑ Yes ❑ No

9. Have you ever been diagnosed with Tuberculosis (TB)? ❑ Yes ❑ No
   Have you been exposed to Tuberculosis (TB)? ❑ Yes ❑ No
   Have you ever been treated for Tuberculosis (TB)? ❑ Yes ❑ No
   Have you been experiencing night sweats, coughing up blood, & a persistent cough for > 3 weeks? ❑ Yes ❑ No

10. Have you ever had trouble with your heart? (Heart attack, irregular heart beat, Mitral Valve Prolapse,Congestive Heart Failure (CHF), heart murmur, congenital defects, etc? ❑ Yes ❑ No
    Have you ever taken medications for your heart? ❑ Yes ❑ No
    Do you ever have pain or pressure in your chest? ❑ Yes ❑ No

11. Have you ever had high blood pressure requiring treatment? ❑ Yes ❑ No

12. Have you ever had any liver disease (hepatitis, yellow jaundice, etc.)? ❑ Yes ❑ No

13. Have you been diagnosed with HIV / AIDS? ❑ Yes ❑ No

14. Do you take medications for heartburn, reflux, ulcers, hiatal hernia, or indigestion? ❑ Yes ❑ No

15. Have you ever had a stroke, mini−stroke, seizure, or frequent headaches? ❑ Yes ❑ No

16. Do you have any paralysis or severe numbness/weakness in your arms or legs? ❑ Yes ❑ No
    Do you have a neuromuscular disease? (Parkinson's, Multiple Sclerosis, Myasthenia Gravis, etc.) ❑ Yes ❑ No
    Do you have arthritis? ❑ Yes ❑ No
    Are you under the care of a Rheumatologist? (Lupus, Gout, Rheumatoid Arthritis, Fibromyalgia) ❑ Yes ❑ No

LAST, FIRST MNAME ROOM−BED s
V1234 t 04/30/2008 M1234 **m**
04/30/2008 *00M 07D*

COFFEE REGIONAL MEDICAL CENTER

NURSING/ANESTHESIA PATIENT HISTORY QUESTIONNAIRE

17. Are you limited to which arm you can have a blood pressure or needlestick? ❑ Yes ❑ No
18. Do you have "sugar" diabetes (problems with your blood sugar)? ❑ Yes ❑ No
19. Do you have thyroid disease? ❑ Yes ❑ No

20. Do you bleed easily or take a blood thinner? ❑ Yes ❑ No
Have you ever had a blood transfusion? ❑ Yes ❑ No
Have you been diagnosed with anemia, sickle cell disease or carry sickle cell trait? ❑ Yes ❑ No
Have you ever had a blood clot? ❑ Yes ❑ No Family history of blood clots / blood clotting disorder? ❑ Yes ❑ No

21. Have you recently been treated for or currently have head lice? ❑ Yes ❑ No

FOR WOMEN: 22. Are you pregnant or could you be? ❑ Yes ❑ No
Do you have menstrual cycles or had a menstrual cycle in past 6−12 months? ❑ Yes ❑ No
Have you had a tubaligation or hysterectomy? ❑ Yes ❑ No
Are you currently breastfeeding? ❑ Yes ❑ No

23. Do you have loose/chipped teeth? ❑ Yes ❑ No Wear dentures? (Upper/Lower) ❑ Yes ❑ No
Wear a prosthesis? ❑ Yes ❑ No Wear glasses? ❑ Yes ❑ No Contacts? ❑ Yes ❑ No
Blind? ❑ Yes ❑ No Cataracts/Glaucoma? ❑ Yes ❑ No Have body piercings? ❑ Yes ❑ No
Have trouble hearing? ❑ Yes ❑ No Wear hearing aide? ❑ Yes ❑ No Deaf? ❑ Yes ❑ No

24. Are you on a special diet? ❑ Yes ❑ No If so, what kind?_____
Difficulty swallowing? ❑ Yes ❑ No Eating disorder? ❑ Yes ❑ No
Unplanned weight loss of 10 pounds or more? ❑ Yes ❑ No

25. Do you have any problems with your skin? (eczema, psoriasis, etc.) Rash, burns, lesions, cuts, or bruises? ❑ Yes ❑ No
Do you have any chronic wound(s) or bed sores? ❑ Yes ❑ No
Have you been treated for Methicillin−Resistant Staphylococcus Aureus (MRSA) or Vancomycin−Resistant Enterococci (VRE)? ❑ Yes ❑ No

26. Do you have kidney disease? (kidney failure, polycystic kidney disease, etc.) ❑ Yes ❑ No
Do you have a history of kidney stones? ❑ Yes ❑ No
Do you have problems urinating? (burning, leaking, incontinence, blood in urine, etc.) ❑ Yes ❑ No
Any problems with your bowels? (constipation, diarrhea, bleeding, irritable bowel, etc.) ❑ Yes ❑ No

27. Religion _____Any religious "do's or don'ts" regarding your treatment? ❑ Yes ❑ No

28. Do you need assistance from someone or use an assistive device? (cane, walker, etc.) ❑ Yes ❑ No
Do you live alone? ❑ Yes ❑ No Who will assist with your care after surgery?_____
Who will provide transportation home from your procedure? _____
Do you receive nursing care at home? ❑ Yes ❑ No What agency?_____

29. Are you an Organ Donor? ❑ Yes ❑ No
Do you have a Living Will or Durable Power of Attorney? ❑ Yes ❑ No Does the hospital have a copy? ❑ Yes ❑ No

30. Have you been exposed to communicable diseases (chicken pox, measles, etc.) recently? ❑ Yes ❑ No

31. Have you had a flu shot within the last year? ❑ Yes ❑ No When?_____
Have you ever had a pneumonia vaccine? ❑ Yes ❑ No When?_____

FOR MINORS: 32. Are there any guardianship/custody issues? ❑ Yes ❑ No
33. Are his/her immunizations (shots) up−to−date? ❑ Yes ❑ No

34. Are you currently in pain or having discomfort? ❑ Yes ❑ No Where:_____
What level is the pain? (Circle One) No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

Patient Signature:_____ **Date:**_____

Nurse Signature:_____ **Date/Time:**_____

Pre and Post Op Teaching Given ❑ Yes ❑ No Patient/guardian/spouse/other verbalizes understanding? ❑ Yes ❑ No

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V1234 t 04/30/2008 M1234 **m**
04/30/2008 *00M 07D*

COFFEE REGIONAL MEDICAL CENTER

ASU UNIVERSAL MEDICATION FORM

1MRR

Name: _____ Date of Birth: _____

ALLERGIES (DESCRIBE REACTION)	ALLERGIES (DESCRIBE REACTION)

My Primary Physician's Name is:_____

My Pharmacy Name is:_____

Bring all medicines with you to Pre−Op and Surgical appointments.
LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over−the−counter medications (examples: aspirin, antacids). Also include herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

Name of Medication	Dose	Route	How Often	Notes: Reason for Taking, etc.	Date Stopped

Signature

COFFEE REGIONAL MEDICAL CENTER

ASU UNIVERSAL MEDICATION FORM

1MRR

Name: _____ Date of Birth: _____

ALLERGIES (DESCRIBE REACTION)	ALLERGIES (DESCRIBE REACTION)

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Name of Medication	Dose	Route	How Often	Notes: Reason for Taking, etc.	Date Stopped

Signature

COFFEE REGIONAL MEDICAL CENTER

NURSING / ANESTHESIA
CRMC Sleep Screening Questionnaire

1ANES

SURGERY:_____ DATE OF SURGERY:_____

PLEASE COMPLETE THE QUESTIONNAIRE TO THE BEST OF YOUR ABILITY. IT WILL BE REVIEWED BY A NURSE AND ANESTHESIA PROVIDER PRIOR TO YOUR SURGERY. THE INFORMATION YOU PROVIDE IS CONFIDENTIAL.

1. **SNORING:**
   Do you ***snore*** loudly (louder than talking or loud enough to be heard through closed doors)?

   Yes No

2. **TIRED**
   Do you often feel ***tired***, fatigued or sleepy during daytime?

   Yes No

3. **OBSERVED**
   Has anyone ***observed*** you stopping breathing during your sleep?

   Yes No

4. **BLOOD PRESSURE**
   Do you have or are you being treated for high blood ***pressure***?

   Yes No

5. **BMI –**
   BMI more than 28?

   Yes No **BMI Score_____**

6. **Age**
   Age over 50 years old?

   Yes No

7. **NECK CIRCUMFERENCE**
   Neck circumference greater than 17 inches for male, 16 inches for female?

   Yes No

8. **GENDER**
   Gender –male?

   Yes No

SCORE:_____ (Score is number of Yes responses)

❑ **HIGH RISK OF OSA – "YES" TO SIX (6) OR MORE ITEMS–**
Refer patient to their preferred sleep lab for further study/treatment prior to surgery

❑ LOW RISK OF OSA – "YES" TO LESS THAN SIX (6) ITEMS

❑ I understand that I am high risk for OSA but refuse further sleep testing and understand that admission after surgery may be necessary.

_____

Patient signature Date/Time

ANES_9183_EFR
Rev. 07/15/2013

COFFEE REGIONAL MEDICAL CENTER

PRE−SURGICAL CASE REQUEST

CALL TO SCHEDULE CASE AT EXT 6919

1SCR

Fax Medical Clearance, Orders, Medication List and Case Request to OR @ 383−5632 and Registration @ 389−2165

DATE:	PATIENT NAME:		Surgeon:
DOB:	SOCIAL SECURITY #:	SEX:	PRIMARY CARE PHYSICIAN:
PATIENT PHONE #:		PREADMIT DATE:	PREADMIT TIME:
SURGERY DATE:	SURGERY TIME:	SURGERY DURATION:	

PATIENT HISTORY (ABNORMAL FINDINGS MAY INDICATE NEED FOR MEDICAL/CARDIAC CLEARANCE)

HISTORY OF:	☑	MEDICATIONS	☑
High Blood Pressure		Blood Pressure	
Heart Attack/Murmur		Heart Medicines	
Stroke		Diuretic	
Diabetes		Blood Thinners	
Asthma/Emphysema		Insulin	
Sleep Apnea		MAO Inhibitors	
Recent Hospitalization	Date:	Other	

PERIOPERATIVE RISK ASSESSMENT (COMPLETE PRIOR TO PREADMISSION TESTING APPOINTMENT)

DATE CLEARED:				PHYSICIAN:					
HEIGHT		WEIGHT		BLOOD PRESSURE		LMP		DUE DATE	
ALLERGIES									

CLINICAL INFORMATION

1	PATIENT TYPE ❑ OPS ❑ IP STATUS ❑ ELECTIVE ❑ URGENT	URGENT JUSTIFICATION:
2	DIAGNOSIS CODES (ICD10)− SURGERY AND TESTING	DIAGNOSIS DESCRIPTION
3	PROCEDURE CODES	PROCEDURE DESCRIPTION
4	NERVE BLOCK: ❑ 64450− Popliteal ❑ 64415− Interscalene ❑ 64447− Femoral ❑ 76942−US Guidance for Block ❑ Other:	
5	SPECIAL EQUIPMENT INSTRUCTIONS: ❑ C− ARM ❑ X − RAY _____ ❑ PATHOLOGY ❑ IMPLANTS _____ −VENDOR _____ −Rep Phone#	ADDITIONAL SPECIAL INSTRUCTIONS: ❑ Post OP Bed Required ❑ Post OP Critical Care Bed Required ❑ Other: _____

INSURANCE CLEARANCE (Fax Ins cards, authorizations, referrals to 389−2165) − LIST primary and secondary plans

INSURANCE	POLICY NUMBER		INSURANCE STATUS CHECK: ❑ Insurance is in network for hospital and surgeon ❑ Benefits cover scheduled procedure ❑ Insurance reviewed for referral requirements ❑ Addendum E reviewed for IP only procedures ❑ Request date within 30 days of request for Medicaid
PRECERT STATUS ❑ APPROVED ❑ DENIED ❑ PENDING	AUTH/REF #	UNITS:	

EFFECTIVE FOR DOS 10/1/2015, ONLY ICD 10 CODES WILL BE ACCEPTED.

COFFEE REGIONAL MEDICAL CENTER

NURSING / ANESTHESIA
CRMC Sleep Screening Questionnaire

1ANES

SURGERY:_____ DATE OF SURGERY:_____

PLEASE COMPLETE THE QUESTIONNAIRE TO THE BEST OF YOUR ABILITY. IT WILL BE REVIEWED BY A NURSE AND ANESTHESIA PROVIDER PRIOR TO YOUR SURGERY. THE INFORMATION YOU PROVIDE IS CONFIDENTIAL.

1. **SNORING:**
   Do you ***snore*** loudly (louder than talking or loud enough to be heard through closed doors)?

   Yes No

2. **TIRED**
   Do you often feel ***tired***, fatigued or sleepy during daytime?

   Yes No

3. **OBSERVED**
   Has anyone ***observed*** you stopping breathing during your sleep?

   Yes No

4. **BLOOD PRESSURE**
   Do you have or are you being treated for high blood ***pressure***?

   Yes No

5. **BMI –**
   BMI more than 28?

   Yes No **BMI Score_____**

6. **Age**
   Age over 50 years old?

   Yes No

7. **NECK CIRCUMFERENCE**
   Neck circumference greater than 17 inches for male, 16 inches for female?

   Yes No

8. **GENDER**
   Gender –male?

   Yes No

SCORE:_____ (Score is number of Yes responses)

❑ **HIGH RISK OF OSA – "YES" TO SIX (6) OR MORE ITEMS–**
Refer patient to their preferred sleep lab for further study/treatment prior to surgery

❑ LOW RISK OF OSA – "YES" TO LESS THAN SIX (6) ITEMS

❑ I understand that I am high risk for OSA but refuse further sleep testing and understand that admission after surgery may be necessary.

_____

Patient signature Date/Time

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COFFEE REGIONAL MEDICAL CENTER

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1SCR

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DOB:	SOCIAL SECURITY #:	SEX:	PRIMARY CARE PHYSICIAN:
PATIENT PHONE #:		PREADMIT DATE:	PREADMIT TIME:
SURGERY DATE:	SURGERY TIME:	SURGERY DURATION:	

PATIENT HISTORY (ABNORMAL FINDINGS MAY INDICATE NEED FOR MEDICAL/CARDIAC CLEARANCE)

HISTORY OF:	☑	MEDICATIONS	☑
High Blood Pressure		Blood Pressure	
Heart Attack/Murmur		Heart Medicines	
Stroke		Diuretic	
Diabetes		Blood Thinners	
Asthma/Emphysema		Insulin	
Sleep Apnea		MAO Inhibitors	
Recent Hospitalization	Date:	Other	

PERIOPERATIVE RISK ASSESSMENT (COMPLETE PRIOR TO PREADMISSION TESTING APPOINTMENT)

DATE CLEARED:				PHYSICIAN:					
HEIGHT		WEIGHT		BLOOD PRESSURE		LMP		DUE DATE	
ALLERGIES									

CLINICAL INFORMATION

1	PATIENT TYPE ❑ OPS ❑ IP STATUS ❑ ELECTIVE ❑ URGENT	URGENT JUSTIFICATION:
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5	SPECIAL EQUIPMENT INSTRUCTIONS: ❑ C− ARM ❑ X − RAY _____ ❑ PATHOLOGY ❑ IMPLANTS _____ −VENDOR _____ −Rep Phone#	ADDITIONAL SPECIAL INSTRUCTIONS: ❑ Post OP Bed Required ❑ Post OP Critical Care Bed Required ❑ Other: _____

INSURANCE CLEARANCE (Fax Ins cards, authorizations, referrals to 389−2165) − LIST primary and secondary plans

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COFFEE REGIONAL MEDICAL CENTER

NURSING/ANESTHESIA PATIENT HISTORY QUESTIONNAIRE

3OR

SURGERY:_____ DATE OF SURGERY:_____

Height_____ Weight_____ Marital Status_____ V/S: T_____ P_____ R_____BP_____SpO2_____

1. Please list the operations you have had in your life, including: Dates (month/year), Doctor, Hospital:

   Organ Transplant? ❑ Yes ❑ No Which organ:_____
2. Please list any medical conditions you have or have had (high blood pressure, diabetes, heart attack, etc.)

3. Are you allergic to latex? ❑ Yes ❑ No Are you allergic to any food, medications, or other (specify what and type of reaction)?

4. Have you or anyone in your family ever had a reaction to a local or general anesthetic? ❑ Yes ❑ No

5. Have you ever been diagnosed with cancer? (specify if current or past) ❑ Yes ❑ No

6. Do you smoke? ❑ Yes ❑ No How many packs per day?_____For how many years? _____
   Have you recently quit smoking? ❑ Yes ❑ No How long ago & for how long have you quit?_____
   Do you chew tobacco / snuff? ❑ Yes ❑ No Do you use "street drugs"? ❑ Yes ❑ No
   If so, explain_____ How much beer, wine, or liquor do you drink per day? _____

7. Have you currently or in the past been treated for a mental / emotional condition? ❑ Yes ❑ No

8. Have you had a chest cold or chest infection in the last month? ❑ Yes ❑ No
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   Have you been exposed to Tuberculosis (TB)? ❑ Yes ❑ No
   Have you ever been treated for Tuberculosis (TB)? ❑ Yes ❑ No
   Have you been experiencing night sweats, coughing up blood, & a persistent cough for > 3 weeks? ❑ Yes ❑ No

10. Have you ever had trouble with your heart? (Heart attack, irregular heart beat, Mitral Valve Prolapse,Congestive Heart Failure (CHF), heart murmur, congenital defects, etc? ❑ Yes ❑ No
    Have you ever taken medications for your heart? ❑ Yes ❑ No
    Do you ever have pain or pressure in your chest? ❑ Yes ❑ No

11. Have you ever had high blood pressure requiring treatment? ❑ Yes ❑ No

12. Have you ever had any liver disease (hepatitis, yellow jaundice, etc.)? ❑ Yes ❑ No

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16. Do you have any paralysis or severe numbness/weakness in your arms or legs? ❑ Yes ❑ No
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    Do you have arthritis? ❑ Yes ❑ No
    Are you under the care of a Rheumatologist? (Lupus, Gout, Rheumatoid Arthritis, Fibromyalgia) ❑ Yes ❑ No

LAST, FIRST MNAME ROOM−BED s
V1234 t 04/30/2008 M1234 **m**
04/30/2008 *00M 07D*

COFFEE REGIONAL MEDICAL CENTER

NURSING/ANESTHESIA PATIENT HISTORY QUESTIONNAIRE

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19. Do you have thyroid disease? ❑ Yes ❑ No

20. Do you bleed easily or take a blood thinner? ❑ Yes ❑ No
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Have you ever had a blood clot? ❑ Yes ❑ No Family history of blood clots / blood clotting disorder? ❑ Yes ❑ No

21. Have you recently been treated for or currently have head lice? ❑ Yes ❑ No

FOR WOMEN: 22. Are you pregnant or could you be? ❑ Yes ❑ No
Do you have menstrual cycles or had a menstrual cycle in past 6−12 months? ❑ Yes ❑ No
Have you had a tubaligation or hysterectomy? ❑ Yes ❑ No
Are you currently breastfeeding? ❑ Yes ❑ No

23. Do you have loose/chipped teeth? ❑ Yes ❑ No Wear dentures? (Upper/Lower) ❑ Yes ❑ No
Wear a prosthesis? ❑ Yes ❑ No Wear glasses? ❑ Yes ❑ No Contacts? ❑ Yes ❑ No
Blind? ❑ Yes ❑ No Cataracts/Glaucoma? ❑ Yes ❑ No Have body piercings? ❑ Yes ❑ No
Have trouble hearing? ❑ Yes ❑ No Wear hearing aide? ❑ Yes ❑ No Deaf? ❑ Yes ❑ No

24. Are you on a special diet? ❑ Yes ❑ No If so, what kind?_____
Difficulty swallowing? ❑ Yes ❑ No Eating disorder? ❑ Yes ❑ No
Unplanned weight loss of 10 pounds or more? ❑ Yes ❑ No

25. Do you have any problems with your skin? (eczema, psoriasis, etc.) Rash, burns, lesions, cuts, or bruises? ❑ Yes ❑ No
Do you have any chronic wound(s) or bed sores? ❑ Yes ❑ No
Have you been treated for Methicillin−Resistant Staphylococcus Aureus (MRSA) or Vancomycin−Resistant Enterococci (VRE)? ❑ Yes ❑ No

26. Do you have kidney disease? (kidney failure, polycystic kidney disease, etc.) ❑ Yes ❑ No
Do you have a history of kidney stones? ❑ Yes ❑ No
Do you have problems urinating? (burning, leaking, incontinence, blood in urine, etc.) ❑ Yes ❑ No
Any problems with your bowels? (constipation, diarrhea, bleeding, irritable bowel, etc.) ❑ Yes ❑ No

27. Religion _____Any religious "do's or don'ts" regarding your treatment? ❑ Yes ❑ No

28. Do you need assistance from someone or use an assistive device? (cane, walker, etc.) ❑ Yes ❑ No
Do you live alone? ❑ Yes ❑ No Who will assist with your care after surgery?_____
Who will provide transportation home from your procedure? _____
Do you receive nursing care at home? ❑ Yes ❑ No What agency?_____

29. Are you an Organ Donor? ❑ Yes ❑ No
Do you have a Living Will or Durable Power of Attorney? ❑ Yes ❑ No Does the hospital have a copy? ❑ Yes ❑ No

30. Have you been exposed to communicable diseases (chicken pox, measles, etc.) recently? ❑ Yes ❑ No

31. Have you had a flu shot within the last year? ❑ Yes ❑ No When?_____
Have you ever had a pneumonia vaccine? ❑ Yes ❑ No When?_____

FOR MINORS: 32. Are there any guardianship/custody issues? ❑ Yes ❑ No
33. Are his/her immunizations (shots) up−to−date? ❑ Yes ❑ No

34. Are you currently in pain or having discomfort? ❑ Yes ❑ No Where:_____
What level is the pain? (Circle One) No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

Patient Signature:_____ **Date:**_____

Nurse Signature:_____ **Date/Time:**_____

Pre and Post Op Teaching Given ❑ Yes ❑ No Patient/guardian/spouse/other verbalizes understanding? ❑ Yes ❑ No

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