LANDMARK HOSPITAL

Landmark Hospital of Southwest Florida
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Patient Pre-Admission Telephone Questionnaire

Patient Name: _____ D.O.B. ___ / ___ / ___ Date of Procedure: ___ / ___ / ___

Patient Phone Number: _____ Height: _____ Weight: _____

Scheduled Procedure/Surgery: _____
Surgeon: _____
Family Physician: _____

Do you have any allergies or sensitivities to medications, dyes, any kind of tape, latex, food, etc…… If yes, to what: _____ What type of reaction do you have: ☐ Rash ☐ Hives ☐ Nausea ☐ Swelling ☐ Trouble breathing	☐ Yes	☐ No
Do you take any medications every day? (including OTC, vitamins/supplements/herbs). If yes, bring to hospital List of Medications: _____ _____ _____ _____	☐ Yes	☐ No
Note: if you are currently taking herbal/diet remedies, we recommend they be stopped two weeks prior to your procedure or surgery		
Do you have a history of hay fever, seasonal allergies or sinusitis……..	☐ Yes	☐ No
Could you be pregnant? LMP: _____ ☐ Post- menopausal Female ☐ Male Patient	☐ Yes	☐ No
Have you ever smoked cigarettes…. …… If yes, how many a day: _____ For how long: _____ Do you smoke now: _____	☐ Yes	☐ No
Do you drink alcohol……..... If yes, how often: _____ What kind: _____ How much: _____	☐ Yes	☐ No
Do you use any illicit drugs..... If yes, how often: _____ What kind: _____ How much: _____	☐ Yes	☐ No
Have you ever had an operation before…… If yes, what type and when: _____	☐ Yes	☐ No
Do you remember what type of anesthesia you had…….. ☐ General ☐ Spinal ☐ Epidural ☐ Local	☐ Yes	☐ No
Have you ever had a problem with anesthesia…… If yes, what: _____	☐ Yes	☐ No
Has anyone in your family ever had a problem with anesthesia or history of Malignant Hyperthermia……... If yes, what: _____	☐ Yes	☐ No
Do you have a history of post procedure or post-surgical nausea or vomiting……	☐ Yes	☐ No
Do you have a history of nasal, facial, head or neck injuries……	☐ Yes	☐ No
Do you have braces, bridges, caps, crowns, dentures or retainers……..	☐ Yes	☐ No
Do you have any broken, chipped, missing or loose teeth……	☐ Yes	☐ No
Do you have glasses, contacts or hearing aids……	☐ Yes	☐ No
Do you have any prosthetics or orthopedic implants……..	☐ Yes	☐ No
Have you ever had a heart attack or have a heart condition……	☐ Yes	☐ No
• Have you ever experienced chest pain, pressure in your chest, palpitations or an irregular heart beat…..……	☐ Yes	☐ No
• Have you ever had an abnormal electrocardiogram (EKG)……..	☐ Yes	☐ No
• Have you ever experienced shortness of breath……	☐ Yes	☐ No
• Have you ever experienced high blood pressure……	☐ Yes	☐ No
Do you snore……	☐ Yes	☐ No

Do you suspect or have you been diagnosed with Sleep Apnea……	☐ Yes	☐ No
• If yes, have you had a sleep study performed……	☐ Yes	☐ No
Do you wake at night with shortness of breath……	☐ Yes	☐ No
Do you have any difficulty breathing while climbing stairs……	☐ Yes	☐ No
Have your lungs ever filled with fluid or do you have a history of congestive heart failure……	☐ Yes	☐ No
Can you lie flat in bed without getting short of breath……	☐ Yes	☐ No
Has anyone ever told you that you have a heart murmur or that you need antibiotics before dental work……	☐ Yes	☐ No
Have you seen a cardiologist within the last year…… If yes, Cardiologist: _____ Telephone: _____ Address: _____	☐ Yes	☐ No
Do you have a history of asthma, pneumonia, bronchitis, emphysema, wheezing or tuberculosis……	☐ Yes	☐ No
• Have you ever had an abnormal chest x-ray……	☐ Yes	☐ No
• Do you cough daily……	☐ Yes	☐ No
• Have you had a recent cough or cold……	☐ Yes	☐ No
Have you seen a lung specialist within the last year…… If yes, Pulmonologist: _____ Telephone: _____ Address: _____	☐ Yes	☐ No
Do you have any problems with your liver……	☐ Yes	☐ No
• Have you ever had hepatitis or jaundice……	☐ Yes	☐ No
Have you been diagnosed with HIV/AIDS……	☐ Yes	☐ No
Do you have ulcers, gastritis, hiatal hernia, heartburn or regurgitation……	☐ Yes	☐ No
Do you have diabetes or trouble with your blood sugar……	☐ Yes	☐ No
Do you have trouble with your thyroid……	☐ Yes	☐ No
Have you ever had kidney trouble or kidney stones……	☐ Yes	☐ No
Have you ever had a seizure, stroke, dizziness, fainting spells or weakness in your arm or legs……	☐ Yes	☐ No
Do you have a history of auto-immune disease……	☐ Yes	☐ No
Do you have anemia (low red blood cells), bleeding problems, frequent nose bleeds, blood clots or bruise easily……	☐ Yes	☐ No
• Do you or a member of your family have sickle cell anemia……	☐ Yes	☐ No
Do you have cancer or have you received radiation or chemotherapy……	☐ Yes	☐ No
Have you ever had a blood transfusion……	☐ Yes	☐ No
• If yes, have you ever experience a blood transfusion reaction……	☐ Yes	☐ No
Do you have a history of falls or use mobility devices (cane, walker, wheelchair)……	☐ Yes	☐ No
Have you ever been diagnosed with MRSA (methicillin resistant staph aureus)……	☐ Yes	☐ No
Do you have a Living Will or other Advanced Directives (make sure to bring to the hospital)……	☐ Yes	☐ No
Any medical conditions we did not ask you about…… If yes, provide:_____ _____ _____ _____	☐ Yes	☐ No

Nursing Notes/Comments: _____
_____
_____
_____
_____
_____

RN Completing Questionnaire: _____ Date: _____ Time: _____