LANDMARK HOSPITAL™

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Pre-Surgical Health History

Patient – Please begin here and complete the information below: *Place a checkmark next to the question if it applies to you or your history:*	
	Seizure/stroke or other neurological condition
	History of heart conditions
	Chest pressure/pain
	Shortness of breath with exertion or exercise
	Pacemaker or defibrillator
	Cardiac stent/blood vessel stent or cardiac bypass
	High blood pressure
	Blood thinner medication or clotting problems
	Take aspirin, Motrin, Aleve, etc.
	Blood disorder
	Autoimmune disease
	Lung problems or trouble breathing
	History of tobacco use
	Use supplemental oxygen
	Sleep apnea
	Kidney problems
	Gastrointestinal or liver problems
	Thyroid, parathyroid or adrenal gland problems
	Cancer treated with chemotherapy or radiation
	Currently have a contagious or infectious condition
	Diabetes, high blood sugar or hypoglycemia
	Taken steroids (such as prednisone) in the last year
	Suffer from anxiety, depression or panic attacks
	Mental health concerns
	Used recreational drugs within the last three days
	Consumed alcohol within the last three days
	Dentures or problems with your teeth
	Eye or vision problems
	Hearing problems
	Physical restrictions
	Frequent heartburn or acid reflux
	Object to blood products under any circumstances
	Problems with anesthesia (self or a relative)
	I have concerns about anesthesia
	Possibility of pregnancy
	Currently breastfeeding
	Date of your last menstrual period:
	I have an Advanced Directive
	I would like information about an Advanced Directive
	I have concerns about help once I go home

Name/Phone Number of Ride Home:

_____

I grant the hospital permission to go over procedural information, medications and discharge instructions with my ride home: ○ Yes ○ No

Patient/Representative Signature: _____

Patient – Continue to questions below:

Please list belongings brought to the hospital:

○ Wallet ○ Purse ○ Jewelry ○ Cell Phone
○ Dentures ○ Partials ○ Glasses ○ Hearing Aid
○ Other:

I need more information on the following:

○ Medications ○ Current illness ○ Rehab therapy
○ Diet/nutrition ○ Home care ○ Equipment
○ Treatment ○ Follow-up care ○ Resources
○ Other:

Pain Assessment:

I currently have pain: ○ No ○ Yes – complete the following:

Pain Level (0-10) _____ Location: _____

Onset/Duration: _____

Description: ○ Dull ○ Sharp ○ Burning ○ Aching

Current Treatment *(Check all that apply):* ○ Medication ○ Ice
○ Elevation ○ Heat ○ Massage ○ Other: _____

Acceptable Level of Pain: _____

The following to be completed by Pre-Op Nurse:

Oriented to: ○ Person ○ Place ○ Time

LOC: ○ Alert ○ Drowsy ○ Other: _____

Behavior: ○ Calm ○ Restless ○ Anxious ○ Other: _____

Patient / Responsible Party Teaching:

○ Pre-procedural / Pre-surgical and Pain Management
○ Infection Prevention and Control
○ Plan of Care Reviewed and any concerns addressed
○ Verbalized Understanding

Baseline Vital Signs:

T _____ B/P _____ / _____ P _____ RR _____ Sat _____ %

Blood Glucose: _____ Normal Range: _____ ○ NA

○ Entire assessment and pre-admission forms reviewed. List any barriers and measures taken to address and/or narrative notes:

_____

_____

_____

_____

_____

_____

_____

○ Ride home verified (Required)

Pre-op RN Signature: _____

Date: _____ Time: _____