Columbus Community Hospital Anesthesia & Nursing Questionnaire

Directions: Please complete all areas and return it to hospital admissions clerk upon preadmission.

Patient name:_____ Telephone number:_____

Age:_____ Sex: Male Female Height:_____ Weight:_____lbs.

Person to accompany patient home:_____ Telephone number:_____

Do you have a living will? _____Yes _____No Medical Power of Attorney? _____Yes _____No

If yes on file at_____

Type of surgery or procedure:_____ Surgeon:_____

Local pharmacy: _____ Phone number: _____

Please list all the medication you take on the attached medication list.

Drug or food allergies: None or list:

List all the operations you have had:

MEDICATION HISTORY

Yes	No	Have you had chemotherapy for cancer?
Yes	No	Have you taken aspirin or aspirin products or motrin in last 2 weeks?
Yes	No	Have you taken steroids in the past 12 months?
Yes	No	Are you taking birth control pills?
Yes	No	Do you take herbs? St. John's Wort? Ginkoba? Others?

ANESTHESIA HISTORY

Yes	No	Have you or any family members had any difficulty with anesthesia in the past?
Yes	No	Have any family members died or had a high temperature related to anesthesia?

RESPIRATORY

Yes	No	Asthma
Yes	No	Emphysema
Yes	No	Bronchitis; date of last episode_____
Yes	No	Pneumonia; date of last episode_____
Yes	No	Shortness of breath
Yes	No	Recent cold or respiratory infection
Yes	No	COPD (Chronic Lung Disease)
Yes	No	Tuberculosis
Yes	No	Smoker; _____pks/day for_____yrs
Yes	No	Dip or chew tobacco

CARDIOVASCULAR

Yes	No	High blood pressure
* Yes	No	Chest pain/pressure; last episode:_____
* Yes	No	Irregular heart beat / Palpitations
Yes	No	Pacemaker
* Yes	No	Heart attack; When_____?
* Yes	No	Congestive heart failure; CHF
* Yes	No	Coronary artery disease
Yes	No	Elevated cholesterol
Yes	No	Rheumatic fever
Yes	No	Murmur / Heart valve disease
* Yes	No	Abnormal EKG
Yes	No	Circulation problems; peripheral vascular disease
* Yes	No	Sickle-Cell Anemia or trait
Yes	No	Blood clotting problems or bleeding disorders

LIVER

Yes	No	Alcohol; frequency_____
Yes	No	Street drugs; _____
Yes	No	Hepatitis; liver disease, yellow jaundice

GASTROINTESTINAL

Yes	No	Ulcer / Rectal bleeding
Yes	No	Nausea / vomiting; within last 2 wks
Yes	No	Abdominal pain
Yes	No	Chronic heart burn / reflux / GERD / Hiatal hernia
Yes	No	Unexplained weight loss in the past six months
Yes	No	Poor nutrition (unbalanced diet)

MUSCULO-SKELETAL

Yes	No	Osteoarthritis arthritis; degenerative
Yes	No	Rheumatoid arthritis
Yes	No	Low back pain
Yes	No	Metal implants or artificial joints

(Continue on page 2)

CUESTIONARIO DE ANESTESIA Y CUIDADO DE LOS ENFERMOS

COLUMBUS COMMUNITY HOSPITAL

Direcciones: Por favor complete todas areas y devuelvalo al empleado de admision del hospital al tiempo de preadmision.

Nombre de paciente:_____ Numero de telefono:_____

Edad:_____ Sexo: Hombre Mujer Estatura:_____ Peso:_____libras

Persona quien va a acompanar el/la paciente a casa:_____ Numero de telefono:_____

¿Tiene un testamento en vida? _____Si _____No Poder Médico? _____Si _____No

Si es así: en los archivos de _____

Tipo de cirugia o procedimiento:_____ Cirujano:_____

Escriba una lista de medicina que usted toma en la hoja de medicación adjunta.

Farmacia:_____ Número de teléfono: _____

Alergias a drogas o comida: Ningun o Escriba una lista:_____

_____

Escriba una lista de todos tipos de operaciones que usted ha tenido:_____

_____

Historia de Medicina

Si No Usted ha recibido quimioterapia para cancer?

Si No Usted ha tomado aspirina o productos de aspirina o motrin en las ultimas dos semanas?

Si No Usted ha tomado esteroide en los pasados doce meses?

Si No Usted esta tomando medicina para control de la natalidad?

Si No Usted toma yerbas? St. John's Wort? Ginkoba? Otras?

Historia de Anestesia

Si No Usted o algun miembro familiar ha tenido cualquier dificultad con anestesia en el pasado?

Si No Ha muerto algun familiar o ha tenido una temperatura alta relacionada a la anestesia?

Respiratorio

Si No Asma

Si No Enfisema

Si No Bronquitis; fecha del ultimo episodio

Si No Pulmonia; fecha del ultimo episodio

Si No Falta de respiracion

Si No Catarro reciente o infeccion respiratorio

Si No COPD (Chronic Lung Disease = Enfermedad cronico de los pulmones)

Si No Tuberculosis

Si No Fumador _____paquetes al dia por _____ anos

Si No Inmersion o mastique tabaco

Patient Sticker

Cardiovascular

Si No Presion sanguinea alta

* Si No Dolor del pecho/presion, ultimo episodio _____

* Si No Latido irregular del corazon / palpitaciones

Si No Marcapasos (estabilizador del ritmo cardiaco)

* Si No Ataque cardiaco; cuando_____.

* Si No Insuficiencia cardiaca congestiva; CHF

* Si No Enfermedad de arteria coronaria

Si No Colesterol elevado o colesterol alto

Si No Fiebre reumatica

Si No Sonido anormal del corazon / enfermedad de la valvula del corazon

* Si No Electrocardiograma anormal

Si No Problemas con circulacion; enfermedad del vascular periferico

* Si No Anemia de globulos / falciformes

Si No Problemas con propiedad de coagulacion de sangre o desordenes sangramientos

Higado

Si No Alcohol; frecuencia_____

Si No Drogas ilegales:_____

Si No Hepatitis; enfermedad del higado; ictericia amarilla

Gastrointestinal

Si No Ulcera; sangramiento del recto

Si No Nausea; vomitando dentro de las ultimas dos semanas

Si No Dolor abdominal

Si No Acedia cronica / reflujo / GERD / hernia atraves del hiato esofagico del diafragma

Si No Baja de peso inexplicada en los ultimos seis meses

Si No Mala nutricion / alimentacion (dieta no balanceada)

Musculoesqueletico

Si No Osteoartritis artritis; degenerativo

Si No Artritis reumatoidea

Si No Dolor bajo de la espalda

Si No implantes metales o coyunturas artificiales

(Continue al otro lado)

EVALUACIÓN DE ANESTESIA Y CUIDADO PREOPERATONO

NEURO

Yes No Multiple Sclerosis
Yes No Stroke; When:_____
Yes No TIA's
Yes No Migraine headaches
Yes No Seizure; date of last episode
Yes No Loss of consciousness
Yes No Muscle weakness / Paralysis
Yes No Fainting episode
Yes No Myasthenia Gravis

RENAL

Yes No Kidney disease
Yes No Kidney stones
Yes No Dialysis
Yes No Urinary retention
Yes No Urinary frequency

MISCELLANEOUS

Yes No Hearing aids
Yes No Glasses / Contacts

ENDOCRINE

Yes No Diabetes
Yes No Thyroid disease
Yes No Other endocrine (hormone) disorders

DENTAL HARDWARE (Circle all that apply)

Yes No Capped teeth / Bridges / Braces / Retainer
Yes No Dentures; Upper / Lower / Partial
Yes No Chipped / Cracked / Loose / Missing

FEMALE PATIENTS

Yes No Are you pregnant? (or possibly)
Date of last menstrual period: Postmenopausal

Any other medical problems not listed:

X _____ **Date:** _____
Signature of person completing this form:
Relationship to patient: Self Spouse Parent

FOR HOSPITAL STAFF USE ONLY – PREOP TEACHING

☐ Preop Med ☐ Positioning ☐ Cast/Dressing ☐ Supplemental Oxygen
☐ Preop Scrub ☐ Monitoring ☐ PACU ☐ Drains, Foley, NGT
☐ NPO ☐ IV line ☐ Cough & Deep Breath ☐ Discharge from PACU
☐ Surgery Room ☐ Other **Nurse's Signature**_____ **Date**_____

ANESTHESIA & NURSING PHYSICAL ASSESSMENT / PREOP COUNSELING

BP **P** **R** **T** **$Sp0_2$** **%** **Pt Id:** ☐ Verbal ☐ ID Band

MENTAL STATUS
☐ Oriented
☐ Awake
☐ Calm
☐ Apprehensive
☐ Confused
☐ Unresponsive
☐ Uncooperative

RESPIRATORY
☐ Clear; bilateral
Rales;
RUL RML RLL LUL LLL
Rhonchi;
RUL RML RLL LUL LLL

CARDIOVASCULAR
☐ Regular ☐ Irregular
☐ Murmur
Radial pulse present:
☐ Left ☐ Right
Pedal pulse present:
☐ Left ☐ Right

GASTROINTESTINAL
Bowel sounds
☐ Present ☐ Absent
ABDOMEN
☐ Non-distended
☐ Distended
☐ Non-tender
☐ Tender

SOCIAL
☐ Live alone
☐ Live with family
☐ Nursing home
ADMITTED
☐ Ambulatory
☐ Wheelchair
☐ Stretcher

NPO since:_____ **IV:**_____ Ga., **Site** L R_____

Advanced Directive Information: ☐Given ☐Declined

Comments:

_____ _____
Nurse's Signature **Date** **Time**

Physical Status 1 2 3 4 5 E

Planned Anesthetic / Special Monitors: (circle) A-line, EDM, Central line
Risks, benefits, procedures, and alternatives of planned anesthetic care discussed with patient and/or parent or guardian.
Plan accepted for **General / Spinal / Epidural / Axillary / Interscalene / T.I.V.A. / IV Regional / M.A.C. / Postop Pain Management /**

Airway: F.R.O.M. / R.O.M. M.P. I II III IV

EKG CXR

Hgb / Hct / Plt

PT INR
PTT Other

Comments:
☐ BETA BLOCKER YES NO
☐ Preoperative assessment reviewed with patient.

Date & Time of Last Dose:_____

CRNA
Evaluator Signature: **Date:** **Time:**

History and physical reviewed and updated. For topical ophthalmic cases only.

Signed **Date:**

POSTANESTHESIA ASSESSMENT

☐ Patient without complaint and no apparent post anesthetic sequelae.
☐ See Progress notes.

Signed **Date:**

Addressograph

Anesthesia & Nursing Preoperative Assessment (page 2)

Neuro

Si No Esclerosis multiple
Si No Apoplejia; cuando _____
Si No TIA's
Si No Dolor de cabeza migrana
Si No Ataque repentino; fecha del ultimo episodio _____
Si No Perdida del conocimiento
Si No Debilidad de los musculos; paralisis
Si No Episodios de desmayo
Si No Miastenia grave

Renal

Si No Enfermedad de los rinones
Si No Piedras renales / en los rinones
Si No Dialisis
Si No Retencion urinaria
Si No Frecuencia urinaria

Miscelanio

Si No Audifono / aparato de audicion/oido
Si No Lentes (anteojos) / lentes de contactos

Endocrino

Si No Diabetes
Si No Enfermedad de la glandula tiroides
Si No Otros desordenes endocrinos (hormona)

Aparatos Dentales (Circule todos aplicables)

Si No Dicntcs con coronas / pucnte dental / frenos / retenedor
Si No Denturas: alto bajo parcial
Si No Dientes quebrados / sueltos / desmolados

Pacientes que son Mujeres

Si No Esta embarazada? (Hay la posibilidad?)
Fecha del ultimo menstruacion _____ Postmenopausia

Cualquier otro problema medico que no esta en la lista:

X _____ Fecha: _____

Firma de persona completando esta forma:
Relacion al paciente: si mismo esposo(a) padres

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☐ Surgery Room ☐ Other

Nurse's Signature _____ Date _____

ANESTHESIA & NURSING PHYSICAL ASSESSMENT / PREOP COUNSELING

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Nurse's Signature **Date** **Time**

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EKG CXR

Hgb / Hct / Plt

PT INR

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CRNA

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Signed **Date:**

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Signed Date:

Addressograph

EVALUACIÓN DE ANESTESIA Y CUIDADO PREOPERATONO
COLUMBUS COMMUNITY HOSPITAL

COLUMBUS COMMUNITY HOSPITAL
MEDICATION LIST

TO HELP US BETTER PLAN YOUR CARE; PLEASE LIST ALL MEDICATIONS YOU TAKE DAILY, INCLUDING HERBAL SUPPLEMENTS AND VITAMINS.

MEDICATION	DOSAGE/STRENGTH	WHEN TAKEN