

PRE-PROCEDURE and ADMISSION SCREENINGS

PATIENT INFORMATION

Home phone _____ Work phone _____ Local/cell phone _____
 Would it be best to call you at home work Can we leave a message? Yes No
 Home Address _____ City _____ State _____ E-mail _____
 Primary care physician _____ Phone _____ Fax _____
 Emergency contact _____ Phone _____ Relation _____

ADMISSION SCREENINGS

ALLERGIES	Reaction	Reaction	Other Allergies	Reaction
<input type="checkbox"/> No known		<input type="checkbox"/> Fish/shellfish		
<input type="checkbox"/> Penicillin	_____	<input type="checkbox"/> Avocado	_____	_____
<input type="checkbox"/> Sulfa	_____	<input type="checkbox"/> Chestnuts	_____	_____
<input type="checkbox"/> Contrast dye	_____	<input type="checkbox"/> Banana	_____	_____
<input type="checkbox"/> Latex	_____	<input type="checkbox"/> Kiwi	_____	_____

Pain
Using the pain scale below, how bad is your pain today?
 0 1 2 3 4 5 6 7 8 9 10
 No Mild Mod Severe Very Worst
 Pain Pain Pain Pain Severe Pain

Blood Administration
Do you refuse a blood transfusion? No Yes

Communication/Learning
Check all that apply
 Hearing impaired
 Wears hearing aid
 Visually impaired
 Wear glasses/contacts
 Speak English
 Understand English
 Read English
 Speak Spanish
 Other language _____
 Learns best by Seeing Hearing Doing

Functional Screening
I have problems
 Walking
 Transferring in/out of bed/toilet
 Bathing/dressing
 Toileting
 Taking medications
 Communicating wants/needs
 Understanding/memory
 Swallowing
 Falling
 No items apply

Nutrition Screening
 Unable to eat Pregnant Breast-feeding
 > 5 lb wt loss last 3 months
 Trouble swallowing or chewing problems
 Special diet _____
 No items apply

Psycho/Social
Are you presently seeing a mental health worker for counseling? No Yes

Do you smoke? No Yes **Ever smoked?** No Yes
 If so, _____ packs / per day / for _____ yrs
Quit in the last 12 months No Yes
Are you interested in information to help you quit smoking? No Yes

Do you drink alcohol? No Yes
 how much _____ how long _____

Are you currently using recreational drugs?
 No Yes

Have you ever been abused physically, verbally or sexually harmed or felt threatened by someone at home/work?
 No Yes You will be given a brochure if YES is checked

Spiritual
Is there anything we need to know about your values / beliefs in order to provide good care for you?
 No Prayer Sacraments Religious reading
 To see my own faith representative Dietary needs
 Blood/drug restrictions

Do you have any body piercing? No Yes If so, where _____
Have you ever been told you have an infection that is resistant to antibiotics? No Yes
 If yes, MRSA VRE other _____ Don't know
 If patient answers yes, send notification to UCH Infection Control Team

