Pre-Surgical Patient Intake

Please complete intake history once you are scheduled for surgery. The ASH Nurse Navigator Team will be reaching out to you discuss your scheduled surgery plan and what to expect.

The completed intake can be dropped off in person at ASH at the front desk, or faxed or mailed to:

Attn: Nurse Navigators
575 Rivergate Lane
Durango, CO 81301

ASH Nurse Navigator Office: 970-385-2356
Fax: 970-385-2387

Patient Information

Name: ____ DOB: ___________ Age: _______

Height: _______ Weight: _______ Best Phone Number to Reach You: ______________________

Alternate Number: __________________

Do you have an Advanced Directive? □Advanced Directive □Living Will □Power of Attorney □None

Surgery Information

Date of Surgery: ____________ Surgeon: ______________ Type of Surgery: ___________

Caregiver Information

<u>You must have a ride to take you home and stay with you overnight after surgery</u>.

Notify the Nurse Navigator Office if you have any questions.

Name: _________________________Relationship: _____________Phone number: _____________

Name: _________________________Relationship: _____________Phone number: ______________

Surgical History

Date of Previous Surgery	Type of Surgery	Surgeon	Facility	List Any Complications

Anesthesia Screening

Have you ever had anesthesia? □ YES □ No

Have you had problems w/ anesthesia in the past? □ YES □ No

If yes, describe (confusion, vomiting, delirium): ____

____

Do you have a family history of anesthesia problems? □ YES □ No

If yes, describe (Fever, Malignant Hyperthermia, Death) __________________________________

____

Primary Care Provider

PCP Name	PCP Phone	Date of Last Visit

Specialist Provider(s) (Cardiologist, Pulmonologist, etc.)

Specialist Name	Specialist Phone	Date of Last Visit

Animas Surgical Hospital

Pre-Surgical Patient Intake

Recent Diagnostic Tests (Lab work, ECG, X-Ray)

Date of Testing	Testing Facility

Allergies/Medication Sensitivities

Diagnosed Allergy:	Type of Reaction:	Medication:	Reaction:

Current Level of Activity

□ None (sedentary) □ Light (light housework) □ Moderate (walking) □ Active (biking, hiking)

How Often? □Daily □1-2 x/wk □ 3-5 x/wk

Walking/Activity Assistance: □ Independent □ Partial Assist □ Full Assist □ Non-ambulatory

□ Cane □ Crutches □ Walker □ Wheelchair

Social History

Tobacco use: □ Never Smoker □ Former Smoker □ Current Smoker Years used: ________

Packs per day: _____ Year Quit:__________

Alcohol use: □ None □Rare □Occasional □Frequent (drinks/day): ______________

Marijuana use: □ None □ Rare □Occasional □Frequent List Type: ______________________________

Other Drug use (please specify): ____

Do you feel safe at home? □ Yes □No

Immunization History

Pneumonia: □ YES □ No Flu: □ YES □ No Tdap: □ YES □ No

Date: _________________ Date: _______________ Date: ________________

Other Immunizations:

Type: __________________ Type: ___________________

Date: __________________ Date: ___________________

Psychiatric Screening

Anxiety/Panic □ YES □ No Depression □ YES □ No

Bipolar/Mania □ YES □ No Schizophrenia □ YES □ No

Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Neurological Screening

Seizures/Epilepsy □ YES □ No Headaches/migraines □ YES □ No

Muscle weakness □ YES □ No Spinal cord abnormality □ YES □ No

Animas Surgical Hospital

Pre-Surgical Patient Intake

Stroke/paralysis/TIA ☐ YES ☐ No Dementia/Alzheimer ☐ YES ☐ No

Please List Date of Diagnosis and Current Treatment for all Yes Questions:

Sensory Devices

Contacts ☐ YES ☐ No Hearing Aides ☐ YES ☐ No R or L; Glasses ☐ YES ☐ No

____

____

Cardiovascular Screening

High Blood Pressure	☐ YES	☐ No	Pacemaker/Defibrillator	☐ YES	☐ No
Valve prolapse	☐ YES	☐ No	Coronary Artery Bypass Grafts	☐ YES	☐ No
Palpitations	☐ YES	☐ No	Heart attack	☐ YES	☐ No
Stent(s) (year)	☐ YES	☐ No	High Cholesterol	☐ YES	☐ No
Chest pain/angina	☐ YES	☐ No	Irregular Heart Beat	☐ YES	☐ No
Angioplasty (year)	☐ YES	☐ No	Rheumatic fever	☐ YES	☐ No
Congestive heart failure	☐ YES	☐ No	Heart murmur	☐ YES	☐ No

Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Respiratory Screening

Sleep Apnea ☐ YES ☐ No

Do you use a CPAP/Bipap? ☐ YES ☐ No

If yes, describe (At night? How often? With oxygen?)

____

Emphysema ☐ YES ☐ No

Do you use Oxygen? ☐ YES ☐ No

If yes, describe (At night? How Often? How many Liters?)

____

Asthma/Wheezing ☐ YES ☐ No

Bronchitis/cough ☐ YES ☐ No

Allergies/sinusitis ☐ YES ☐ No

Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Gastrointestinal Screening

Ulcers ☐ YES ☐ No

Reflux/heartburn ☐ YES ☐ No

Hiatal Hernia ☐ YES ☐ No

Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Animas Surgical Hospital

Pre-Surgical Patient Intake

Endocrine/Kidney/Liver Screening

Diabetes (Type I or II) □ YES □ No Kidney failure □ YES □ No
Hepatitis □ YES □ No Dialysis (schedule) □ YES □ No
Thyroid (hypo or hyper) □ YES □ No
Please List Date of Diagnosis, Type if applicable, and Current Treatment for all Yes Questions:

____

____

Musculoskeletal Screening

Arthritis/TMJ □ YES □ No Gout □ YES □ No
Fibromyalgia □ YES □ No Back Pain □ YES □ No
Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Integumentary

Non-healing sores □ YES □ No
Shingles □ YES □ No
Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Cancer

Cancer (type) □ YES □ No If yes, describe (Date Diagnosed, Type, Where in Body)

____

Is your cancer in Remission? □ YES □ No (Date) ____________________________________
Chemotherapy □ YES □ No (Last Treatment) ____
Radiation □ YES □ No (Last Treatment) ____

Bleeding disorders

Blood clots (legs/lungs) □ YES □ No
Hemophilia □ YES □ No
Please List Date of Diagnosis and Current Treatment for all Yes Questions:

____

____

Infectious Disease Screening

MRSA □ YES □ No Have you been swabbed or 'cleared' of MRSA? □ YES □ No
Date: __________ Treated: □ Yes □No Location of MRSA: ___________________________
HIV/AIDS □ YES □ No
Date Diagnosed: ______________ Last Treatment: _________________________
Current Treatment: ____
TB □ YES □ No Type: □Latent □ Active
Date Diagnosed: _______________Date Treatment Completed: ____________________________
Hepatitis □ YES □ No

Animas Surgical Hospital

Pre-Surgical Patient Intake

Type: A□ B□ C□ Date Diagnosed: ________________
Last Treatment: ____________________ Current Treatment: ______________________
C-Diff □ YES □ No Date Diagnosed: __________________ Treatment: _______________________

Pediatric-(Pediatric Patients Only)

Premature birth □ YES □ No If yes, describe:
____
Who has custody? ____
Developmental delay □ YES □ No If yes, describe:
____
Other:____
____

We appreciate you taking the time to fill out this form. It helps us take excellent care of you while at Animas Surgical Hospital.

Is there anything else we need to know?
____
____

Home Medication List

Please list below all medications, including over the counter and supplements, that you are currently taking.

Med Name	Strength	Frequency	Route	Reason	Physician Prescribed
**EX: Lisinopril	10mg	2 day	Oral	Blood Pressure	Ciotti