Animas Surgical Hospital

We appreciate you for taking the time to fill out this form.

Patient Information

Name: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Best Phone Number to Reach You: _____

Alternate Number: _____

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

Planned Surgery Information

Date of Surgery: _____ Surgeon: _____ Type of Surgery: _____

Have you attended the on-line class or viewed the available videos for Total Joint Replacement or Spine surgery offered by ASH? □ YES □ No

Caregiver Information:

You must have an adult sign for your discharge and take you home from the hospital

Name: _____Relationship: _____Phone number: _____

Surgical History: Please list all previous surgeries and any complications:

_____

_____

_____

_____

_____

Anesthesia Screening

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

If yes, describe (confusion, vomiting, Malignant Hyperthermia, delirium): _____

_____

Has anyone you are related to by blood ever had problems with anesthesia meaning high fevers requiring extended hospitalization, malignant hyperthermia or sudden death? □ YES □ No

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

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

Date of Testing and Facility:

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Medication Allergies: □ No □ YES Are you allergic to Latex? □ Yes □ No

If YES, Please list *Medication* allergies, the reaction you had (ie:hives, rash, blisters, etc) and if the reaction was a mild, moderate or severe 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

Activity Assistance: □ Independent □ Cane /walking stick □ Crutches □ Walker □ Wheelchair

Social History

Tobacco use: □ Never □ Former Smoker □ Current Smoker □ Smokeless tobacco □ E Cigs □ Vaping
Age started tobacco: _____ Pack/vapes/pouch/can _____# per day Age Quit tobacco: _____
Alcohol use: □ None _____# Drinks per Day/Week/Month
Marijuana use: □ None Edibles/Smoke/Vape/CBD:_____ # per Day/Week/Month
Other Substance use (please specify): _____
Who lives at home with you?_____
Is there Emotional or Physical abuse in your life currently? □ Yes □No
In the past 2 weeks, have you been bothered by feeling down, depressed or hopeless? □ YES □ No

Immunization History

Pneumonia Vaccination: □ YES □ No Date: _____ Flu Vaccination: □ No □ YES Date: _____
Tetanus (Tdap): □ Within 5 years or □ Greater than 5 years COVID Vaccination/booster □ No □ YES

Psychiatric

Anxiety/Panic □ YES □ No Depression □ YES □ No Schizophrenia □ YES □ No
Bipolar Disorder □ YES □ No PTSD □ YES □ No Claustrophobia □ YES □ No

Neurological

Seizures/Epilepsy □ YES □ No Headaches/migraines □ YES □ No Stroke/paralysis/TIA □ YES □ No
Muscle weakness □ YES □ No Spinal cord abnormality □ YES □ No _____
Dementia/Alzheimer's □ YES □ No Parkinson's Disease □ YES □ No Other:_____

Auto-Immune Disease

Lupus □ YES □ No IBS □ YES □ No Grave's Disease □ YES □ No Multiple Sclerosis □ YES □ No
Rheumatoid Arthritis □ YES □ No Crohn's Disease □ YES □ No Other Auto-Immune Disorder_____

Endocrine

Diabetes (Type I or II) □ YES □ No Thyroid/ Parathyroid Disease □ YES □ No Other:_____

Bleeding/ Clotting Disorders

Have you ever had a blood clot in your leg or lung? □ No □ YES Date:_____
Hemophilia □ No □ YES Factor V Leiden □ No □ YES Other Bleeding/clotting disorder_____
Family members with bleeding/clotting disorder? □ No □ YES

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Cardiovascular

High Blood Pressure	□ YES	□ No	Pacemaker/Defibrillator	□ YES	□ No
Valve prolapse	□ YES	□ No	Coronary Artery Bypass Grafts	□ YES	□ No
Palpitations	□ YES	□ No	Heart attack (year)_____	□ 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
Atrial Fibrillation	□ YES	□ No	Other Heart Problems:_____		

Respiratory

Have you been tested for Sleep Apnea? □ YES □ No Do you have Sleep Apnea? □ YES □ No
Do you use a CPAP/Bipap? □ YES □ No If YES: With Oxygen____ # Liters / Without Oxygen
Do you use Oxygen? □ YES □ No _____ (#)Liters Nightly / 24 hours
Seasonal Allergies/sinusitis □ YES □ No ASTHMA/Wheezing □ YES □ No Bronchitis/ Chronic cough □ YES □ No
COPD □ YES □ No Emphysema □ YES □ No Other Lung Disease_____

Gastrointestinal

Gastric Ulcers □ YES □ No Gastric Reflux/Heartburn □ YES □ No Hiatal Hernia □ YES □ No
Other GI Disease_____

Kidney/Bladder/Prostate

Kidney Stones □ YES □ No Kidney Disease □ Yes □ No Dialysis □ No □ YES How Often_____
Enlarged Prostate □ YES □ No Incontinence □ YES □ No Bladder Issues:_____

Musculoskeletal

Arthritis □ YES □ No Osteoporosis □ YES □ No Gout □ YES □ No Curvature of the Spine □ YES □ No
Back Pain □ YES □ No Degenerative Joint Disease □ YES □ No Fibromyalgia □ YES □ No
Neuropathy (numbness in extremity) □ YES □ NO Restless Leg syndrome □ YES □ No
Herniated Disc □ No □ Yes -Where: Neck/ Back
Other Musculoskeletal Disorder/ Joint Pain:_____

Integumentary/Skin

Non-healing sores □ YES □ No Psoriasis/ Eczema □ YES □ No Shingles □ YES □ No Skin Cancer □ YES □ No

Cancer

Cancer □ No □ YES- describe (Date Diagnosed, Type, Where in Body)

_____

Is your cancer in Remission? □ No □ Yes (Date) _____
Chemotherapy □ No □ YES Last Treatment: _____ Radiation □ No □ Yes Last Treatment: _____

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Infectious Disease

Have you ever had MRSA? □ No □ YES Date: _____ Where on your body_____
HIV/AIDS □ No □ Yes Date Diagnosed: _____ Last Treatment for AIDS/HIV: _____
TB □ YES □ No Treatment Received □ No □Yes Last Treatment for TB: _____
Hepatitis □ No □ Yes Type: A□ B□ C□ Date Diagnosed: _____Last Treatment: _____
C-Diff □ No □ Yes Date Diagnosed: _____
COVID-19: Positive test within 30 days □ No □ Yes Positive test greater than 30 days □ No □ Yes

Pediatric Information (For Pediatric Patients Only)

Premature □ NO □ YES, describe: _____ Developmental delay □ No □YES, describe: _____
Immunizations Current □ YES □ No
Who has Legal custody? _____ Documentation of Guardianship MUST be submitted

HOME MEDICATION LIST:

PLEASE LIST ALL PRESCRIPTION MEDICATIONS AND SUPPLEMENTS THAT YOU ARE ***CURRENTLY*** TAKING

Medication Name	**Dose (mg)**	**Frequency (am, pm, as needed)**		**Reason you take this medication**	
Your Preferred Pharmacy:		**Pharmacy Phone #:**			

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