



# JOHNS HOPKINS

M E D I C I N E

THE JOHNS HOPKINS  
HOSPITAL

## PATIENT HISTORY PREOPERATIVE CENTER

for addressograph plate

Gray areas Indicate minimal data elements

**Patient Information**

**PATIENT INSTRUCTIONS:** This questionnaire helps the physicians and nurses evaluate your health and plan your care. Please answer all the questions using a PEN. Indicate with a check mark or write your answer in the space provided. Bring completed form with you and/or complete on the day of admission/treatment.

Today's Date: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ Age: \_\_\_\_\_

Name of person completing form (if NOT patient): \_\_\_\_\_

Patient's Telephone Number: \_\_\_\_\_ Reported Weight: \_\_\_\_\_ Reported Height: \_\_\_\_\_

Please indicate a phone number we may use to contact you the night before surgery: \_\_\_\_\_

Contact person in case of emergency: \_\_\_\_\_ Phone # \_\_\_\_\_

Type of Surgery: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Are there any cultural/religious/family beliefs or values we should be aware of in planning/providing your care?

No  Yes (explain) \_\_\_\_\_

Do you have an Advance Directive? (Example: Living Will or Durable Power of Attorney)  No  Yes

If 'yes', specify: \_\_\_\_\_

Last menstrual period: \_\_\_\_\_  N/A Are you willing to provide a urine sample for pregnancy testing?  No  Yes

We routinely screen all patients for abuse or violence in their lives. Is this a problem for you in any way?  No  Yes

Do you want help with this today?  No  Yes

**Dietary**

Have you had an unexplained loss or gain of weight recently?  No  Yes (describe) \_\_\_\_\_

Are you on a special or restricted diet?  No  Yes (describe) \_\_\_\_\_

Do you have any problems with swallowing?  No  Yes (describe) \_\_\_\_\_

**Functional Status**

Do you wear or have: (Check all that apply)

Colostomy

Ileostomy

Indwelling bladder catheter

Infusion Catheter

Type: \_\_\_\_\_

Do you wear or have: (Check all that apply)

Removable dentures  Partial  Full  Upper  Lower

Hearing aid  Right  Left

Glasses

Contact lenses

False Eye  Right  Left

Prosthesis(es) e.g. Artificial Limb (describe): \_\_\_\_\_

Other (e.g. wheelchair): \_\_\_\_\_

Brought with you?

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Yes  No

Unit Validation (initials)

**Self Care**

How have you managed these activities during the past year?

	Independent	Need Assistance	Comments:		Independent	Need Assistance	Comments:
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	_____	Meal preparation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Walking	<input type="checkbox"/>	<input type="checkbox"/>	_____	Toileting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Transportation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stair climbing	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have any problems sleeping?  No  Yes (describe) \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **History Number:** \_\_\_\_\_

**Discharge Planning**

What special equipment or home services are you using now or have you used in the past 12 months? (Check all that apply)

Cane                       High-Rise Toilet Seat                       Housekeeper

Crutches                       Commode                       Companion / Sitter (Specify provider) \_\_\_\_\_

Wheelchair                       Oxygen                       Home Health Aide (Specify provider) \_\_\_\_\_

Walker                       Phone Amplifier or TDD                       Visiting Nurse (Specify provider) \_\_\_\_\_

Hospital Bed                       Glucose Meter                       Meals on Wheels

Other special equipment or devices used at home: \_\_\_\_\_

**None of these apply**

Do you have a preferred home care agency?    No    Yes (specify) \_\_\_\_\_

Other Community Services: \_\_\_\_\_

Who provides care for you at home?    Self    Other: \_\_\_\_\_

Would you like to see a Social Worker? (for assistance with medical coverage, housing, etc ....)    No    Yes

**Anesthesiology**

1) Have you or any blood relatives had any problems with Anesthesia? \_\_\_\_\_  
Comments? \_\_\_\_\_

2) Can you walk up (2) flights of stairs without chest pain or shortness of breath? \_\_\_\_\_  
Comments? \_\_\_\_\_

3) Do you exercise regularly? \_\_\_\_\_ What type of exercise? \_\_\_\_\_  
\_\_\_\_\_ How often? \_\_\_\_\_ How far can you walk without stopping? \_\_\_\_\_

4) Do you ever wake up short of breath? \_\_\_\_\_

5) Have you ever had Asthma, wheezing, other breathing problems or any lung disease? \_\_\_\_\_  
Comments? \_\_\_\_\_  
If yes to Asthma or wheezing, when was your last wheezing spell? \_\_\_\_\_

6) Any history of seizures, strokes, unexplained vision changes, sudden numbness, sudden weakness or fainting? \_\_\_\_\_  
Comments? \_\_\_\_\_

**Smoking / Alcohol**

Do you smoke?    No    Yes    Cigarettes    Cigars    Pipe   Amount smoked daily: \_\_\_\_\_

Have you smoked in the past?                       No    Yes   Year quit: \_\_\_\_\_

Do you drink alcohol?    No    Yes   How much each day?   Beer \_\_\_\_\_ Wine \_\_\_\_\_ Liquor \_\_\_\_\_

**Allergies**

Are you allergic to any medicines?    No    Yes (specify) \_\_\_\_\_

What kind of reaction do you have? \_\_\_\_\_

Are you allergic to any foods?                       No    Yes (specify) \_\_\_\_\_

Are you allergic to latex/rubber products? (Example: Balloons, Condoms, Paint)    No    Yes (specify) \_\_\_\_\_

**Latex Risk**   Patients with bladder extrophy, myelomeningocele and/or a history of chronic or recurrent instrumentation of the genitourinary tract, spina bifida, or an allergy to avocados, bananas, kiwi, or passion fruit implement the Latex Protocol.

Are you allergic to dyes used for x-rays?    No    Yes (specify) \_\_\_\_\_

Are you allergic to iodine or seafood?                       No    Yes (specify) \_\_\_\_\_

Any other allergies?    No    Yes (specify) \_\_\_\_\_

**Medications**

**Please list all of your current medications on the "HOME" Medication List.**  
(Please include all over the counter medications and supplements.)

Are you taking any Herbal Supplements?    No    Yes   If yes, please list on "HOME" Medication List.

Do you use any "recreational" or "street" drugs?    No    Yes   What type? \_\_\_\_\_

**PATIENTS: Please continue with NEXT PAGE**

Signatures	Validation Signatures/Titles		Time	Date	Validation Signatures/Titles		Time	Date





