JOHNS HOPKINS
MEDICINE

THE JOHNS HOPKINS HOSPITAL
PATIENT HISTORY
PREOPERATIVE CENTER **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 the 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: _____ Weight: _____ Height: _____

Contact Person in case of emergency: _____ Relationship: _____

Contact person's telephone number: _____

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: _____

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

Have you had an unexplained loss or gain of weight recently? ☐ NO ☐ YES (describe) _____

Are you on a special or restricted diet? ☐ NO ☐ YES

Do you have any problems with swallowing? ☐☐

Do you wear or have: (Check all that apply)	Do you wear or have: (Check all that apply)	Brought with you?	Unit Validation (intitials)
☐ Colostomy	☐ removable dentures ☐Partial ☐Full ☐upper ☐ lower	☐ Yes ☐ No	
☐ Ileostomy	☐ Hearing aid ☐ Right ☐ Left	☐ Yes ☐ No	
☐ Indwelling bladder Catheter	☐ Glasses	☐ Yes ☐ No	
☐ Infusion Catheter Type_____	☐ Contact lenses	☐ Yes ☐ No	
	☐ False Eye ☐ Right ☐ Left	☐ Yes ☐ No	
	☐ Prosthesis (es) e.g. Artificial Limb (describe):	☐ Yes ☐ No	
	☐ Other (e.g. wheelchair):	☐ Yes ☐ No	

How have you managed these activities during the past year?

	Independent	Need Assistance	Comments:		Independent	Need Assistance	Comments:

Feeding	☐	☐	Meal preparation	☐	☐
Walking	☐	☐	Toileting	☐	☐
Bathing	☐	☐	Transportation	☐	☐
Dressing	☐	☐	Stair climbing	☐	☐

Do you have any problems sleeping? ☐ No ☐ Yes (describe) _____

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)
☐ Hosptial 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

Please list all the medicines you currently take (include non-prescription medicines)

Name of Medicine	How Much (Dosage)	How Often	Name of Medicine	How Much (Dosage)	How Often

In the past 12 months have you had any difficulty getting prescriptions filled? ☐ No ☐ Yes

If yes, check all that apply: ☐ Financial Need ☐ Availability ☐ Other: (described) _____

Do you use any other drugs not listed above? ☐ No ☐ Yes What drugs? _____

Do you smoke? ☐ No ☐ Yes ☐ Cigarettes ☐ Pipe ☐ Cigars 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 _____

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) _____

Foods associated with latex Allergies: (✓ if allergic) ☐ Kiwi ☐ Bananas ☐ Passion Fruit ☐Avocados

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) _____

TO BE COMPLETED BY UNIT PERSONNEL:

Medications brought to hospital (list): _____

Disposition of medication brought from home: ☐ Sent Home ☐ Nursing Unit (location): _____

Signature: _____ Date/Time: _____

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

_____			_____		

Check all that apply to you now, or have applied to you in the past.

Describe your exercise tolerance

☐ Bedridden ☐ Able to walk with assistance ☐ Active (over 2 flights of steps or comparable with ease)
☐ Limited (less than 1 flight of steps) ☐ Moderate (1-2 fights of steps or comparable) ☐ Regular exercise

Heart Disease

☐ High Blood Pressure …..☐ On medication for high blood pressure
☐ Chest Pain……...☐ With activity……..☐ At rest
☐ Chest Pain combined with: ☐ difficulty breathing ☐ sweatiness ☐ nauseated feeling
☐ Heart attack Date:_____ give name of hospital where treated: _____
☐ History of heart attacks in your immediate family (parents, brothers, or sisters)
☐ Heart surgery or angioplasty Date: _____ Give name of hospital where treated: _____ ☐ Heart rhythm problem or palpitations ☐ Pacemaker Last Checked: _____
☐ Heart Valve problem or congenital abnormality. Describe: _____

Special Heart Testing (Please bring all NON-JOHNS HOPKINS medical reports with you)

☐ Exercise stress test	Date: _____	Hospital/Dr: _____
☐ Echocardiogram	Date: _____	Hospital/Dr: _____
☐ Thallium	Date: _____	Hospital/Dr: _____
☐ Cardiac catheterization	Date: _____	Hospital/Dr: _____
☐ Electrocardiogram (EKG)	Date: _____	Hospital/Dr: _____

Lung Disease

☐ Asthma/Wheezing ☐ Bronchitis ☐ Emphysema ☐ Cystic Fibrosis ☐ Sleep Apnea
☐ Lung Cancer ☐ Tuberculosis ☐ Other: _____

Regarding the above lung problems, have you…..(check all that apply)

☐ been on steroids (prednisone, medrol, or cortisone) within past 2 years? When? _____
☐ Been admitted to the hospital within past 2 years? When? _____
☐ been seen in an Emergency Room within past 2 years? When? _____
☐ been on antibiotics within past 6 months? When? _____
☐ had a chest x-ray within the last 6 months? (Bring all **NON-JOHNS HOPKINS** reports with you)
Where? _____When?_____
☐ undergone breathing tests? (Bring all **NON-JOHNS HOPKINS** reports with you)
Where? _____ When? _____

Other Medical Conditions

☐ Kidney disease
☐ Dialysis ☐ Transplant
☐ Bladder/Urinary disorder (infections)
☐ Adrenal disease
☐ Stomach ulcers
☐ Diabetes
☐ Insulin ☐ Pills ☐ Diet controlled
☐ Thyroid ☐ On Thyroid medications
☐ Sickle Cell
☐ Excessive Bleeding (dental work, easy bruising)
Describe: _____
☐ Family History of Excessive Bleeding
☐ Blood Clots (Lets or Lungs) When: _____
☐ Blood Transfusion within last 3 months
Neuromuscular Disease
Describe: _____
☐ Arthritis ☐ Jaw ☐ Neck ☐ Other joints
☐ Liver disease
☐ Hepatitis (yellow Jaundice) When?_____
☐ Other liver disease? _____

☐ Fainting spells
☐ Neurologic disease
☐ Parkinsons disease
☐ Seizures ☐ on medication for seizures
☐ Stroke When?_____
☐ Hiatal Hernia
☐ Unable to lie flat without heartburn

☐ Back Problems
☐ Neck ☐ Thoracic ☐ Low back
☐ Previous back injury
☐ Previous back surgery
☐ Now taking blood thinners (coumadin, heparin)
☐ Taken aspirin or aspirin containing medications within the ☐ last week
☐ Taken anti-inflammatory medicines in the past 4 days
☐ + HIV
☐ Cancer (type): _____
☐ Any other illness (specify)? _____

Anesthesia/Surgical History

Do you refuse blood transfusions: ☐ NO ☐ Yes
Have you donated your own blood for THIS operation ☐ NO ☐ Yes
Have you ever had general anesthesia (put to sleep) for an Operation before? ☐ NO ☐ Yes
Have you ever had a spinal or epidural before? ☐ NO ☐ Yes
Were there any problems with either of the above procedures? ☐ NO ☐ Yes
If yes describe: _____

Please list all past operations or hospital stays.

Reason	Year	Check here if you were admitted to Intensive Care
		☐
		☐
		☐
		☐
		☐
		☐