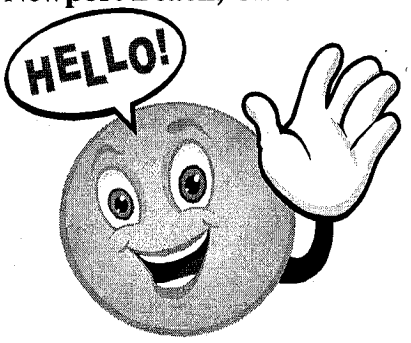
Hoag Newport Center Surgicare
1441 Avocado Ave Suite 100
Newport Beach, CA 92660



STEPS YOU NEED TO DO BEFORE YOUR SURGERY:

1): **CALL TO PRE-REGISTER**
(949) 764-8424
as soon as possible .

2) **Please fill-out the two page health history forms attached and bring it with you the day of surgery.**

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Age: _____

Stated Height: _____ Stated Weight: _____ Primary Language: _____ Contact Person: _____

Telephone Numbers: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Procedure: _____ Date of Procedure: _____

Physician performing procedure: _____ Primary Care Physician: _____

Internist: _____ Last seen: _____ Cardiologist: _____ Last seen: _____

ALLERGIES and ALLERGY REACTIONS:

LIST PREVIOUS SURGERIES: Year Complications Type of Anesthesia

LIST PREVIOUS CARDIAC/MEDICAL PROCEDURES: angioplasty/stent placement, echocardiogram, stress test, pacemaker or defibrillator model/brand #, and where done

Procedure Year

Please check appropriate box in each section below:

CARDIOVASCULAR	**Yes**	**No**
Hypertension	☐	☐
Heart Attack – Date:_____	☐	☐
Coronary Artery Disease	☐	☐
Cardiomyopathy	☐	☐
Congestive Heart Failure	☐	☐
Arrhythmias i.e. A-Fib	☐	☐
Rheumatic Fever	☐	☐
Heart Valve problems	☐	☐
Heart murmur	☐	☐
Carotid Artery Disease	☐	☐

	Yes	**No**
Angina/Chest Pain	☐	☐
Pain or shortness of breath when walking 2 blocks or climbing 1 flight of stairs	☐	☐
High Cholesterol	☐	☐
Poor Circulation in lower extremities	☐	☐
Family history of heart disease (age of onset)	☐	☐
Father _____ Mother _____ Siblings _____		

PULMONARY	**Yes**	**No**
Asthma	☐	☐
COPD/Bronchitis/Emphysema (circle)	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐

	Yes	**No**
Blood clots in lungs or legs	☐	☐
Sleep Apnea	☐	☐
Chronic Cough	☐	☐
Oxygen Use	☐	☐

Addressograph

[1508]

GASTROINTESTINAL	Yes	No
Hiatal Hernia	☐	☐
Ulcers/GERD/Gastric Reflux (circle)	☐	☐
Gallstones	☐	☐
Liver Disease	☐	☐
Hepatitis A, B or C	☐	☐

GENITOURINARY	Yes	No
Urinary Tract Infections	☐	☐
Kidney Stones	☐	☐
Prostate Disease	☐	☐
Penile Prosthesis	☐	☐
Dialysis	☐	☐

HEMATOLOGIC	Yes	No
Anemia	☐	☐
Bleeding Disorders	☐	☐
Blood Diseases i.e. Leukemia	☐	☐
Blood Transfusions	☐	☐
Easy Bruising	☐	☐

ENDOCRINE	Yes	No
Diabetes	☐	☐
Hypo/Hyperthyroidism	☐	☐
Hypoglycemia	☐	☐

NEUROLOGIC	Yes	No
Stroke/TIA's	☐	☐
Seizures	☐	☐
Multiple Sclerosis	☐	☐
Myasthenia Gravis	☐	☐
Paralysis	☐	☐
Muscle Weakness	☐	☐
Headache	☐	☐
Fainting	☐	☐
Numbness	☐	☐

PAIN	Yes	No
Rheumatoid arthritis	☐	☐
Osteoarthritis	☐	☐
Chronic Pain Treatment	☐	☐
Back/Neck Pain	☐	☐
Artificial Joints	☐	☐

Location: _____

GENERAL HEALTHCARE	Yes	No
Cancer	☐	☐
Location: _____		
Radiation Therapy	☐	☐
Chemotherapy	☐	☐
Immune Deficiency	☐	☐
Measles/Mumps/Rubella (circle)	☐	☐
Chicken Pox	☐	☐
Have you had:		
MMR Vaccine	☐	☐
Flu Vaccine – Date: _____	☐	☐
Pneumonia Vaccine – Year: _____	☐	☐
TB Skin Test	☐	☐
☐ Positive ☐ Negative ☐ Unknown		

Social History:	Yes	No
Do you drink alcohol? Amount: _____	☐	☐
Do you smoke?	☐	☐
Did you ever smoke? Years: _____	☐	☐
Have you smoked in the past 12 months?	☐	☐
Do you use recreational drugs?	☐	☐
Type: _____		
If female: possibility of pregnancy?	☐	☐
Last menstrual period: _____		
History of Malignant Hyperthermia (MH)	☐	☐
Family history of anesthesia problems or MH (circle)	☐	☐

SURGICAL INFORMATION	Yes	No
Do you have any specific needs?	☐	☐
Hearing	☐	☐
Vision	☐	☐
Living alone	☐	☐
Transportation	☐	☐
Insurance	☐	☐
Do you exercise?	☐	☐
Type: _____		

Do you need information on:	Yes	No
Current surgery	☐	☐
Medications	☐	☐
Activities	☐	☐
Home Care	☐	☐
Do you wear contact lenses?	☐	☐
Do you have caps, bridges, dentures or loose teeth?	☐	☐

_____ [Patient/Parent/Conservator/Guardian]

_____ [If completed by other than patient, indicate relationship]

_____ [Date]

THIS SECTION FOR HOAG FACILITY PERSONNEL USE ONLY

_____ [Reviewed by Assessment Nurse] _____ [Date] _____ [Time]

_____ [Reviewed by Procedure Nurse] _____ [Date] _____ [Time]

_____ [Reviewed by PACU Nurse] _____ [Date] _____ [Time]

_____ [Reviewed by Discharge Nurse] _____ [Date] _____ [Time]

HOAG HOSPITAL USE ONLY:

☐ *FAX to Pharmacy after admit physician signs*

PATIENT STATED HOME MEDICATION LIST

Acknowledgement: I confirm that this is a complete and accurate list of my (patient's) current medications, to the best of my knowledge, including prescription and over the counter drugs. I understand that healthcare providers will make medical decisions based on this information. **BRING THIS FORM WITH YOU TO HOAG.**

☐ *Check this box if not on any home medications.*

[Signature of Patient/Responsible Person]

DESCRIBE ALLERGIES & REACTIONS:

Completed by: _____ Date/Time: _____

Source of Medication History: _____

Physician Orders on Hoag Admit

Continue or Formulary Equivalent (circle one)		Medication	Dose	Route	Freq	Reason for Taking	Dose last taken - RN to Complete	On Discharge: Stop	On Discharge: Continue (Next Dose)
Y	N	1.							
Y	N	2.							
Y	N	3.							
Y	N	4.							
Y	N	5.							
Y	N	6.							
Y	N	7.							
Y	N	8.							
Y	N	9.							
Y	N	10.							

Medication Reconciliation on Entry:

_____ [Physician Signature]

Date/Time: _____ ID#: _____

DATE TIME T/O FROM

Noted: ☐ CC/RN: _____ Date/Time: _____

☐ RN: _____ Date/Time: _____

SIGNATURE/TITLE

Medication Reconciliation on Discharge:

_____ [Physician Signature]

Date/Time: ID#:

DISCHARGE: PRINT NEW MEDICATIONS AND CHANGES TO ABOVE MEDICATIONS (PROVIDE PRESCRIPTION TO PATIENT)

Medication	Dose	Route	Freq	Reason	Special Instructions	Medication Schedule				Comments:

Original to patient on discharge. Line through stopped meds.

Discharge RN: _____

Date/Time:

Discharge Physician Signature: _____

Date/Time: ID#:

DATE TIME T/O FROM SIGNATURE/TITLE

MEDICATION RECONCILIATION/ORDERS

Hoag Memorial Hospital Presbyterian

PS 7514 Rev 12/16/10

PLACE IN FRONT OF PHYSICIAN ORDERS

Original – Patient Photocopy 1 – Chart Photocopy 2 – Primary Care Physician

Page ____ of ____ Patient Name _____

[2517]