ORLANDO HEALTH | Health Central Hospital
Surgery Center

CURRENT MEDICATIONS: Prescriptions

1. 4.
2. 5.
3. 6.

SURGICAL HISTORY

ANESTHESIA HISTORY

Have you or a blood relative had a reaction to general or local anesthesia?
☐ Yes ☐ No If yes, please explain: _____

ALLERGIES: Medication / Food / Other

☐ None Known ☐ Latex

Reaction:

Reaction:

HEALTH HISTORY

Height: _____ Weight: _____ Last Menstrual Period: _____

	Yes	No		Yes	No
Anemia	☐	☐	Hypertension	☐	☐
Asthma	☐	☐	Immunodeficiency Disease	☐	☐
Arthritis Pain	☐	☐	Kidney Disease/Stones	☐	☐
Bladder Infection	☐	☐	Liver Problems	☐	☐
Bleeding Problems	☐	☐	Migraines	☐	☐
Cancer	☐	☐	Seizures/Tremors	☐	☐
Chest Pain / Angina	☐	☐	Sickle Cell	☐	☐
Cholesterol	☐	☐	Sleep Apnea	☐	☐
COPD	☐	☐	Stomach Problems	☐	☐
Depression	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Thyroid Disease	☐	☐
Difficulty with:			Tuberculosis	☐	☐
Hearing	☐	☐	Tubes		
Vision	☐	☐	Colostomy	☐	☐
Fainting	☐	☐	Foley	☐	☐
Heartburn / Acid Reflux	☐	☐	JP Drain	☐	☐
Heart Disease	☐	☐	Nephrostomy	☐	☐
Hepatitis - Type:	☐	☐	PICC Line	☐	☐
			Portacath	☐	☐

SPECIAL NEEDS

Dentures: ☐ Y ☐ N Loose Teeth: ☐ Y ☐ N

Glasses: ☐ Y ☐ N Contacts: ☐ Y ☐ N Hearing Aids: ☐ Y ☐ N

Safety

Do you have a history of:	Yes	No		Yes	No
Unsteady walk / balance	☐	☐	Falling	☐	☐
Use a walker / cane / crutch	☐	☐	Use brace	☐	☐

PSYCHOSOCIAL HISTORY

Religious Preferences: _____

Primary Language Spoken: _____

Do you: ☐ Smoke/Use tobacco ☐ Drink beer/alcohol ☐ use caffeine

**** DOMESTIC VIOLENCE HIGH RISK SCREENING**

(>2 "Yes", refer to Nursing Supervisor < 24 hrs)

1.) STRESS/SAFETY: Should I be concerned for your safety? ☐ Yes ☐ No

2.) AFRAID/ABUSE: Are there any personal situations that you have been in that you have felt afraid? ☐ Yes ☐ No

3.) FRIENDS/FAMILY: Does someone need to be aware that you have been threatened/hurt? ☐ Yes ☐ No

4.) EMERGENCY PLAN: Do you need help locating a safe place? ☐ Yes ☐ No

RELATIVE/RIDE INFORMATION

Name and phone number of person 18 years old or older who will be taking you home from surgery / hospital?

Name: _____ Phone: _____

FOLLOW UP CALL INFORMATION:
What number can you be reached at the day after you return home?

SECTIONS BELOW TO BE COMPLETED BY NURSE

Date: ____/____/____ NPO: _____ Proc.: _____
C/C: _____ W/S: _____
☐ Clothes ☐ Cell phone ☐ Wallet ☐ Dentures ☐ Jewelry ☐ Glasses
Other: _____
Rate your Pain: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Description of Pain: _____
B/P: ___ / ___ R ☐ L ☐ Temp:____RR:____Pulse:____O_2Sat:____
IV Site: _____ Time: _____ RN: _____
Urine Pregnancy _____ ; WB Gluc _____ mg/dL Ref. (74mg/dL - 106 mg/dL)
Hgb ____ g/dL Ref (F 12.0 g/dL - 15.5 g/dL) (M 13.0 g/dL - 17.5 g/dL)
RN: _____

Date: ____/____/____ NPO: _____ Proc.: _____
C/C: _____ W/S: _____
☐ Clothes ☐ Cell phone ☐ Wallet ☐ Dentures ☐ Jewelry ☐ Glasses
Other: _____
Rate your Pain: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Description of Pain: _____
B/P: ___ / ___ R ☐ L ☐ Temp:____RR:____Pulse:____O_2Sat:____
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Hgb ____ g/dL Ref (F 12.0 g/dL - 15.5 g/dL) (M 13.0 g/dL - 17.5 g/dL)
RN: _____

Date: ____/____/____ NPO: _____ Proc.: _____
C/C: _____ W/S: _____
☐ Clothes ☐ Cell phone ☐ Wallet ☐ Dentures ☐ Jewelry ☐ Glasses
Other: _____
Rate your Pain: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Description of Pain: _____
B/P: ___ / ___ R ☐ L ☐ Temp:____RR:____Pulse:____O_2Sat:____
IV Site: _____ Time: _____ RN: _____
Urine Pregnancy _____ ; WB Gluc _____ mg/dL Ref. (74 mg/dL - 106 mg/dL)
Hgb ____ g/dL Ref (F 12.0 g/dL - 15.5 g/dL) (M 13.0 g/dL - 17.5 g/dL)
RN: _____

AMBULATORY SURGERY CENTER
PROCEDURE ADMISSION HISTORY

1SUR