STANISLAUS SURGICAL HOSPITAL
1421 Oakdale Road Modesto, CA 95355 209-572-2700

Patient Health Questionnaire

Patient Name:_____ PreAdmit RN:_____

Today's Date:_____ ***FOR HOSPITAL USE ONLY*** ☐ OUTPATIENT ☐ 23 HR OBSERVATION ☐ INPATIENT

Procedure:_____ B/P_____ Heart Rate _____ O_2 Sat _____

Procedure Date/Time: _____ Arrival Time:_____ Height:_____ Weight lb/kg:_____ Temp: _____

□ No Known Drug Allergies □ Allergies / Reactions: _____

_____

		Comments
CARDIAC/CIRCULATORY		
☐Yes ☐No	**1. Heart murmur**	
☐Yes ☐No	**2. Previous heart attack**	
☐Yes ☐No	**3. Chest pain within 1 month**	
☐Yes ☐No	**4. High blood pressure**	
☐Yes ☐No	**5. Irregular heartbeats**	
☐Yes ☐No	**6. Heart procedures**	
☐Yes ☐No	**7. History of Pulmonary Embolism or Blood Clots**	
☐Yes ☐No	**8. Pacemaker, Defibrillator, Deep Brain Stimulator**	
☐Yes ☐No	**Other Cardiac/Circulatory:**	
RESPIRATORY		
☐Yes ☐No	**1. Asthma**	
☐Yes ☐No	**2. Emphysema**	
☐Yes ☐No	**3. COPD**	
☐Yes ☐No	**4. Difficulty breathing while walking 2 blocks**	
☐Yes ☐No	**5. Sleep Apnea**	
☐Yes ☐No	**Other Respiratory:**	
DIABETES		
☐Yes ☐No	**1. Diabetes, Type:**	
☐Yes ☐No	**2. History of low blood sugar**	
☐Yes ☐No	**Other diabetes concerns:**	
NEUROLOGICAL		
☐Yes ☐No	**1. Seizure disorders**	
☐Yes ☐No	**2. Previous stroke or Transient Ischemic Attack(TIA)**	
☐Yes ☐No	**Other neurological concerns:**	
GENITOURINARY PROBLEMS		
☐Yes ☐No	**1. Urinary tract infection within 1 month**	
☐Yes ☐No	**2. Kidney problems**	
☐Yes ☐No	**Other genitourinary concerns:**	
UPPER GASTROINTESTINAL DISORDERS		
☐Yes ☐No	**1. GERD, hiatal hernia, ulcers**	
☐Yes ☐No	**Other upper gastrointestinal concerns:**	
LOWER GASTROINTESTINAL DISORDERS		
☐Yes ☐No	**1. Constipation, diverticulosis/itis, rectal bleed, IBS**	
☐Yes ☐No	**Other lower gastrointestinal concerns:**	
HEPATIC DISORDERS		
☐Yes ☐No	**1. Hepatitis, Type:**	
☐Yes ☐No	**Other hepatic concerns:**	

Patient Health Questionnaire

CANCER OR ANEMIA

☐Yes ☐No 1. Cancer, Type:

☐Yes ☐No 2. Anemia

☐Yes ☐No Other cancer / anemia concerns:

PSYCHOLOGICAL DISORDERS

☐Yes ☐No 1. History of depression or anxiety

☐Yes ☐No Other psychological concerns:

☐Yes ☐No **THYROID DISORDERS**

AUTOIMMUNE DISORDERS

☐Yes ☐No 1. HIV/AIDS

☐Yes ☐No 2. Lupus

☐Yes ☐No 3. Rheumatoid Arthritis

☐Yes ☐No Other autoimmune concerns:

ANY OTHER MEDICAL CONCERNS:

1. **Any open wounds, sores or rashes?** ☐ Yes ☐ No
2. **Are you or could you be pregnant?** ☐ Yes ☐ No
3. **Do you presently have any of the following? (please check)**
   ☐ Cold ☐ Bronchitis ☐ Laryngitis ☐ Fever ☐ Sore throat ☐ Flu
4. **Have you traveled outside of the country within the last 30 days?** ☐ Yes ☐ No
   If Yes, Please explain: _____
5. **Do you have or wear? (please check)**
   ☐ False Teeth ☐ Capped Teeth ☐ Loose Teeth ☐ Retainer ☐ Hearing aids
   ☐ Contact lenses ☐ Glasses ☐ Any Implants ☐ Hard of Hearing ☐ Deaf
6. **Have you or any member of your family experienced any problems with anesthesia, e.g., difficult intubation, malignant hyperthermia, etc?** ☐ Yes ☐ No
   If Yes, Please explain: _____
7. **Do you smoke? (including e-cigarettes):** ☐ Yes ☐ No _____ **Packs per day** **How many years:** _____
8. **Do you drink alcohol?** ☐ Yes ☐ No _____ **Drinks per day**
9. **History of Recreational Drug Use?** ☐ Yes ☐ No **Type:** _____ **Last Used:** _____
10. **Do you have a designated driver over the age of 18 to drive you home after surgery?** ☐ Yes ☐ No

Patient Health Questionnaire

PRIOR SURGERIES

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

MEDICATIONS/VITAMINS & SUPPLEMENTS:

Please include Name, Dose and Frequency

Patient Health Questionnaire

For Hospital Use Only

Patient is a fall risk ☐ Yes ☐ No

Patient has: **Advanced Directive:** ☐ Yes ☐ No **Do Not Resuscitate (DNR):** ☐ Yes ☐ No

☐ *Patient has been advised to bring applicable directives listed above on the day of surgery*

☐ *Advance Directive in charts*

Emergency Contact Name: _____

Relationship to the Patient: _____

Contact Number: _____

Nutritional Assessment:

1 Nausea / Vomiting / Diarrhea greater than 72 hours
1 Difficulty swallowing (rule out dysphagia)
2 Loss of Appetite greater than one week
3 Unintentional weight loss
3 Presence of Pressure ulcer or decubitus

INPATIENT INFORMATION

3 Serum albumin less than 2.9g/dL
3 History of eating disorder
Total = _____
(If greater than 5, advise MD and call Dietary at x2538 for Nutritional Consult and provide score)

☐ HOME HEALTH CARE

☐ REHABILITATION: _____

Diet Restrictions _____

Assistance with activities of daily living? ☐ Yes ☐ No

☐ Pain with walking ☐ Difficulty walking up stairs ☐ Difficulty squatting ☐ Requires assistive device
☐ Difficulty getting out of chair after extended time sitting
☐ Assistive devices must be placed within reach before patient is able to complete grooming activities
☐ Patient is unable to transfer self, bear own weight, or pivot when transferred by another person
☐ Patient requires use of device (eg. Cane, walker) to walk alone or requires human supervision/assistance

INPATIENT INFORMATION:	
Hospital stay in last 30 days	☐ Yes ☐ No
Admitted from another facility (including extended care)	☐ Yes ☐ No
On renal dialysis	☐ Yes ☐ No
History of MRSA	☐ Yes ☐ No
Physician order obtained for PCR swab	☐ Yes ☐ No
Swab completed and sent to lab	☐ Yes ☐ No
Current Pneumonia Vaccine	☐ Yes ☐ Refused ☐Requests Vaccine
Current Flu Vaccine	☐ Yes ☐ Refused ☐Requests Vaccine

Reviewed patient's history to determine if opioid naive or tolerant

☐ **The brochure - if applicable - *Patient and Family Guide to Patient-Controlled Analgesia (PCA)* has been reviewed with patient, and a copy provided to the patient for his/her records**

_____
PreAdmit RN Signature

_____
Date and Time