MID COAST HOSPITAL

AMBULATORY CARE/SURGICAL SERVICES NURSING HISTORY FOR ADULTS

NAME: _____ DATE OF BIRTH: _____

SURGEON: _____ PRIMARY CARE PHYSICIAN: _____

SCHEDULED SURGERY OR PROCEDURE: _____

WHY ARE YOU HAVING THIS PROCEDURE?: _____

HEIGHT: _____ WEIGHT: _____

SURGICAL HISTORY

PAST SURGERY	Date	PAST SURGERY	Date

Have you had any anesthesia complications? ☐ **Yes** ☐ **No**
If Yes, please explain: _____

Has anyone in your family had anesthesia complications? ☐ **Yes** ☐ **No**
If Yes, please explain: _____

Have you had any surgical complications? ☐ **Yes** ☐ **No**
If Yes, please explain: _____

PAST MEDICAL HOSPITAL ADMISSIONS (Non-Surgical)

Admission Reason	Date

DRUG ALLERGIES (LIST REACTION)	LIST FOOD ALLERGIES	ENVIRONMENTAL ALLERGIES
		LATEX ALLERGY? ☐ **Yes** ☐ **No**

Have you had any reaction after handling any rubber products such as rubber gloves, balloons, or condoms? ☐ **Yes** ☐ **No**

(PLEASE CHECK ALL THAT APPLY)

DO YOU HAVE DIFFICULTY WITH?

☐ Swallowing
☐ Speaking
☐ Seeing
☐ Reading
☐ Hearing/Language/Communication
Do you want an interpreter provided?
☐ Yes ☐ No ☐ Not necessary
If one is needed and declined, who will be your interpreter?_____
Primary spoken language:_____

DO YOU USE OR HAVE?

☐ Cane
☐ Crutches
☐ Walker
☐ Wheel Chair
☐ Glasses
☐ Contacts
☐ Hearing Aid
☐ Dentures/partials
☐ CPAP/BIPAP
☐ Hardware/Implants
Please list
_____
_____
_____
_____

DO YOU NEED HELP WITH?

☐ Feeding
☐ Bathing
☐ Dressing
☐ Meal Preparation
☐ Transportation

Do you live alone? ☐ Yes ☐ No
Do you have someone to help you after surgery? ☐ Yes ☐ No
Do you have Home Health Services? ☐ Yes ☐ No
If Yes, name of the agency:_____

FRONT
(PLEASE COMPLETE REVERSE SIDE OF FORM)

MEDICAL HISTORY

HAVE YOU HAD OR ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (PLEASE CHECK ALL THAT APPLY)

☐ High Blood Pressure _____
_____
_____

☐ Heart Attack _____
_____
_____

☐ Heart valve problem/Murmur _____
_____

☐ Irregular Heart Beat _____
_____
_____

☐ Chest Pain _____
_____
Does activity like climbing a flight of stairs cause chest pain?
☐ Yes ☐ No _____
_____

☐ Blood Clot/DVT _____
☐ Breathing problems _____
☐ Emphysema/COPD _____
☐ Asthma _____
☐ Sleep Apnea _____
☐ TB or positive TB Skin Test _____
☐ **Recent** Cold/FLU/Infection _____
☐ Diabetes _____
☐ **If yes,** are you insulin dependent? _____
☐ Liver Problems _____
☐ Peripheral Neuropathy/
Numbness in hands or feet _____
☐ Thyroid Problems _____
☐ Adrenal Gland Problems _____
☐ Anemia _____
☐ Cancer (where?) _____
_____
☐ Diarrhea/Constipation/Bowel Problems _____
☐ Heartburn/GERD/Hiatal Hernia _____
☐ Stomach Ulcers _____

☐ Unexplained recent weight loss or gain _____
☐ Kidney Problems/Stones _____
☐ Bladder Problems _____
☐ Migraines/headaches _____
☐ Stroke/TIA _____
_____
☐ Seizures/Convulsions _____
_____
☐ Difficulty Opening Jaw/TMJ _____
☐ Arthritis _____
☐ Muscle Problems/Paralysis _____
☐ Neck or Back Problems _____
☐ Skin problems _____
☐ MRSA infection _____
☐ Depression/Anxiety/Mental Illness _____
☐ Recreational Drug Use
☐ Alcohol Use _____
How Often? _____ How Much? _____
☐ Tobacco Use
Packs per day _____/ Number of years _____ (PPD/YRS)
Have you quit? _____ When? _____
☐ Currently involved with a Rehab/Treatment program

Any Other Medical Problems we should know about to take care of you? ☐ Yes ☐ No
If Yes, please explain: _____

FEMALES:
First Day of Last Period: _____
Could you be pregnant?..... ☐ Yes ☐ No _____
Are you breast feeding?..... ☐ Yes ☐ No _____

MALES:
Enlarged Prostate..... ☐ Yes ☐ No _____

IMMUNIZATIONS:

Have you had a recent **FLU shot**? When? _____ (Year)
Have you ever had a **Pneumovax** shot? When? _____ (Year)
Tetanus shot up to date? ☐ Yes ☐ No ☐ Unknown

Are you currently in a situation where you feel abused or neglected? ☐ Yes ☐ No
Do you have religious or cultural beliefs that will affect the care we provide? ☐ Yes ☐ No
Do you have a Living Will/Advanced Directive? ☐ Yes ☐ No **If yes, please make sure that the hospital has a current copy.**
If no, do you want information? ☐ Yes ☐ No

Please provide the number where you can be reached on the **morning of your procedure:** (_____) _____
How long will it take for you to get to the hospital? _____

Filled out by Patient ☐ or other _____ (name)

Reviewed by: _____ _____
(Signature of **PAT Nurse**) (Date/Time)

_____ _____
(Signature of **Preop/Admission Nurse**) (Date/Time)

BACK

MID COAST HOSPITAL

MEDICATION HISTORY

Please complete the following section OR bring your personal medication card with you:

Include prescription medications, over the counter medications, herbal supplements, and vitamins.

Drug	**Dose**	**How often taken?**	**Route** (by mouth, inhaler, injection etc.)

Form Completed by: ☐ Patient ☐ Other (name) _____