PACE Adult

Pre-operative Assessment, Consultation, and Education

SCHNECK MEDICAL CENTER
411 West Tipton Street • Seymour, Indiana 47274
www.schneckmed.org

Patient Information

Last Name ______________________ First Name ______________ Middle Initial ________

Mailing Address ______________________ City, State Zip ______________________

Home Phone ______________ Secondary Phone ______________

☐ Full Time ☐ Part Time
☐ Retired ☐ Unemployed
Employment Status

Place of Employment ______________

Employer's Phone Number ______________

Employer Address ______________________ City, State Zip ______________________

_____/______/_________
Date of Birth

☐ Male ☐ Female
Gender

Height ________ Weight ________

Primary Care Physician ______________________ Surgeon ______________________

Reason for the Surgery ______________________ Admitting Diagnosis ______________________

Patient History

Please mark the box if the patient **has a history of** the following conditions:

☐ Blood Transfusions
☐ Anesthesia Reactions
☐ Heart Problems
☐ Heat Stroke
☐ Depression or Anxiety
☐ Previous Surgeries

If yes, please list the reason(s) and date(s):

____
____
____

☐ Hepatitis / Jaundice
☐ Thyroid / Diabetes
☐ Feeding or walking problems
☐ Medication Allergies
☐ Latex Allergies
☐ Hospitalizations

If yes, please list the date(s) of hospitalization(s):

____
____
____

Patient History (Continued)

Please mark the box if the patient **currently has**:

- ☐ Heart Murmurs
- ☐ Breathing / Asthma / Snoring
- ☐ Seizures / Headaches
- ☐ Muscles / Arthritis
- ☐ Any Loose Teeth
- ☐ Scars / Rashes / Tattoos
- ☐ Hypertension / Nosebleeds
- ☐ Nutrition / Swallowing Problems
- ☐ Bladder / Urinary System Problems
- ☐ Stomach / Bowel Problems
- ☐ Liver Problems

Please mark the box if the patient **currently uses**:

- ☐ Hearing Aid(s)
- ☐ Medications
  If yes, please list the medication(s): ____
  ____
- ☐ Walker / Crutches / Wheelchair
- ☐ Glasses or has problems with their eyes

Additional Information

Are there any learning needs? ☐ Yes ☐ No

Are there any religious / cultural practices that would affect treatment or education? ☐ Yes ☐ No

If yes, please describe: ____

At what age did she start her period? ________________

Any possibility that she could be pregnant? ☐ Yes ☐ No

Has there been any exposure to communicable diseases? ☐ Yes ☐ No

Is there a need for isolation? ☐ Yes ☐ No

Are immunizations current? ☐ Yes ☐ No

Does the patient use tobacco products? ☐ Yes ☐ No

If yes, how much? __________________________

Does the patient consume alcohol? ☐ Yes ☐ No

If yes, how much? __________________________

Does the patient use illegal drugs? ☐ Yes ☐ No

If yes, what types and how much? _____________

Hospital Discharge

Who does the patient live with? ☐ Parent(s) ☐ Siblings ☐ Children ☐ Legal Guardian

Are there any new changes or family problems? ☐ Yes ☐ No

Are there any discharge needs? ☐ Yes ☐ No

Who is taking the patient home? __________________________

Is there anyone at home or anyone else available to help with care? ☐ Yes ☐ No

If so, who? ____________________________________

Are there advance directives? ☐ Yes ☐ No

Is the patient an organ donor? ☐ Yes ☐ No

Do you or the patient have any concerns? ☐ Yes ☐ No