



## Patient Information

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Initial

\_\_\_\_\_  
Mailing 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

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

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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
- Walker / Crutches / Wheelchair
- Glasses or has problems with their eyes

If yes, please list the medication(s): \_\_\_\_\_

\_\_\_\_\_

## **Additional Information**

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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**

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

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

## **Parent / Guardian Information**

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\_\_\_\_\_  
Parent(s) Name

\_\_\_\_\_  
Guardian(s) Name

\_\_\_\_\_  
Parent / Guardian Address

\_\_\_\_\_  
City, State Zip

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Secondary Phone

Employment Status:  Full Time  Part Time  Retired  Unemployed

\_\_\_\_\_  
Place of Employment

\_\_\_\_\_  
Employer's Phone Number

\_\_\_\_\_  
Employer Address

\_\_\_\_\_  
City, State Zip