Pre-Admissions Surgical Screening

Do you have or have you ever had any of the following:

HEART / VASCULAR	Yes	No	Comments:	
Heart attack?				HP, EKG, CXR and BMP
Cardiac Bypass or Valve Repair, Heart Valve Disorder or Rheumatic Fever?				
Congestive Heart Failure (too much fluid around your heart)?			☐ BIC card If AA/OP-Bed	
Cardiomyopathy (weak heart muscle)?				
Peripheral Vascular Disease or Claudication?				
High Blood Pressure?				BMP & EKG
Irregular Heartbeat?				
Pacemaker or Defibrillator?			If yes, see Pacemaker/Defibrillator Questionnaire.	
In the past 8 weeks, have you had unexplained or **cardiac-related** chest pain or tightness; angina; shoulder, jaw, arm, neck or mid-back pain; or severe nausea or fatigue?			☐ AMI Best in Class	HP, EKG & CXR
Prior to these past 2 months, have you had any of the above unexplained or **cardiac-related** symptoms?				
Stress test, cardiac cath or echo?			If yes, when: Location:	
Can you walk up a flight of stairs without shortness of breath or chest pain?				

BLOOD	Yes	No	Comments:	
Do you have a recent history of anemia (within the last 6 months)?				HP *PT/PTT
Any blood clotting disorders?*				
Have you had any blood transfusions or pregnancies in the last 3 months?				

RESPIRATORY	Yes	No	Comments:	
• COPD, Emphysema, Chronic Bronchitis?			Do you use oxygen at home?	HP, If >40 pk yrs-EKG, If >40 pk yrs + has smoked in last year-ABG. If sleep apnea-EKG
Currently use tobacco products?			Amount?	
Past Smoker?			For how many years? When did you quit?	
Sleep Apnea?*			Do you use CPAP or BiPAP?	
Have you had a recent Respiratory Infection (last 6 wks)?				
Positive PPD or Chest X-ray positive for Tuberculosis?				CXR

KIDNEY/ENDOCRINE	Yes	No	Comments:	
• Decreased Kidney Function?				HP, EKG, BMP *BMP DOS
On Dialysis?* Peritoneal or Hemodialysis (circle one)			If Hemodialysis, where is your access?_____	
• Diabetes?				BMP EKG (>40yo)
If you have diabetes, do you use an insulin pump?			☐ If yes, complete Insulin Pump form, B-685	
Hypothyroidism? Thyroid disease?				BMP

Pre-Admissions Surgical Screening

LIVER				
	Yes	No	Comments:	
Hepatitis or cirrhosis of the liver?				CMP, PT/PTT
Currently Jaundice?				
Do you drink more than 3 alcoholic beverages a day?				HP, EKG CMP PT/PTT

GENERAL				
	Yes	No	Comments:	
Any present diagnosis of cancer, other than skin cancer?				HP, CXR *EKG
Recent radiation treatment for cancer?*				
Lupus?				HP, EKG CXR, BMP
Scleroderma or Dermatomyositis?				
Rheumatoid Arthritis?				
Osteoarthritis? Psoriatic-arthritis?				MUSCULOSKELETAL
Fibromyalgia?				
Multiple sclerosis?				
Stroke or TIA's?			If yes, date: _____ residual? _____	NEUROLOGICAL
Seizures?			If yes, date of last seizure: _____	
Parkinson's disease?				
Paralysis?				
Peripheral neuropathy?				
Alzheimer's disease or other dementia?				
Recent falls? If so, date of last fall:				
DVT, pulmonary embolism or other blood clot?				VASCULAR
Aneurysm?				
Indigestion, acid reflux or hiatal hernia?				GASTRO-INTESTINAL
An alcohol or substance abuse history?				
Asthma?				PULMONARY
Fever in the past week? If so, how high?_____				☐ Pneumonia (CAP) Best in Class if 2 or more present
Do you have a cough? If so, what color is the sputum? _____				
			For BHC use only: *(Complete only for fever, cough or dyspnea)* ☐ Fever greater than 100.4 or less than 97.6_____ ☐ Oxygen sat less than 90% on room air:_____ ☐ Decreased breath sounds ☐ 65 years or older and change of mental status	

Pre-Admissions Surgical Screening

GENERAL (continued)				
Have you had or do you have any of the following:	Yes	No	Comments:	
Steroid use?				IMMUN-OLOGY
Any history of difficult airway or intubation with a general anesthetic?				GENERAL
Other than nausea/vomiting, have you or any blood relative had a severe reaction to anesthesia, i.e., malignant hyperthermia (MH), pseudocholinesterase deficiency?			If yes, explain:	
Open wounds, current rash, or psoriasis?				
Do you have any specific cultural or religious preferences or needs?				
Indicate how you prefer to learn: ☐ By watching ☐ By doing ☐ By listening				LEARNING BARRIERS

Please continue on the next page

FOR OFFICE STAFF ONLY:

☐ Pre-op test results (labs/EKG/CXR) reviewed and abnormal results faxed_____

Notes:

For AM Admits and OP In a Bed:
☐ PASS Addendum (B-704)
☐ Pain Tool ☐ N/A
☐ Best in Class card ☐ N/A

Pain Assessment

Do you have pain now or have you had pain in the past week? ☐ Yes, continue completing the rest of this page.
☐ No, stop here. Do not complete this page.

Describe Your Pain/Discomfort:

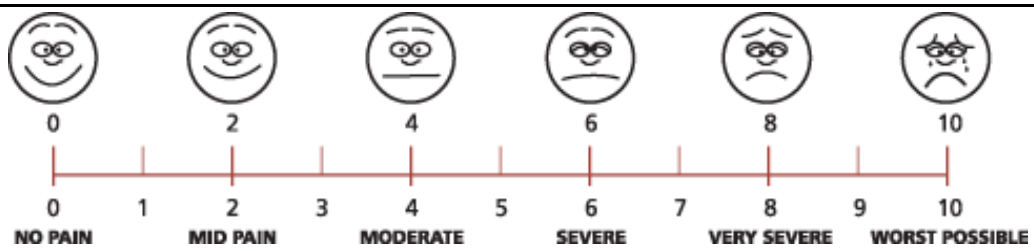
☐ Aching	☐ Cramping	☐ Intermittent	☐ Stabbing	☐ Burning
☐ Shooting	☐ Sharp	☐ Throbbing	☐ Constant	☐ Incisional
☐ Dull	☐ Pins & needles	☐ Labor	☐ Epigastric	☐ Crushing
☐ Other				

_____

Location of Pain/Discomfort:

	☐ Right	☐ Left	☐ Middle	
☐ Head	☐ Facial	☐ Ear	☐ Dental	☐ Mouth/Jaw
☐ Neck/Throat	☐ Chest	☐ Epigastric	☐ Sternal	☐ Shoulder
☐ Upper Arm	☐ Elbow	☐ Forearm	☐ Wrist	☐ Hand/Fingers
☐ Abdomen	☐ Upper back	☐ Mid-back	☐ Lower back	☐ Buttocks
☐ Hip	☐ Thigh	☐ Knee	☐ Calf	☐ Ankle
☐ Foot/Toe	☐ Other_____			

Intensity:



©

What level of pain are you experiencing right now: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What level of pain is acceptable to you: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What is the highest level of pain you have recently experienced: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What is the least level of pain you have recently experienced: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

When did your pain begin? ☐ Past 2 hours ☐ Past 12 hours ☐ Past 24 hours ☐ Past 48 hours
☐ Past week ☐ Past 2 weeks ☐ Past month ☐ Past 3 months
☐ After a procedure, date: _____ ☐ Chronic pain_____

What or when does your pain increase: ☐ NA ☐ Pressure/Touch ☐ Immobility ☐ Ambulation
☐ No cause ☐ Coughing/Breathing ☐ Urination ☐ Bowel movement
☐ Movement ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Bedtime

Associated Symptoms: ☐ NA ☐ Difficulty sleeping ☐ Decreased concentration
☐ Decreased appetite ☐ Constipation ☐ Decreased activity ☐ Increased irritability or mood swings
☐ Depression ☐ Fatigue ☐ Nausea ☐ Other_____

How have you tried to manage this pain: ☐ Nothing

☐ Change of Position	☐ Successful	☐ Unsuccessful	☐ Moving/Ambulating	☐ Successful	☐ Unsuccessful
☐ Warmth	☐ Successful	☐ Unsuccessful	☐ Cold	☐ Successful	☐ Unsuccessful
☐ Massage	☐ Successful	☐ Unsuccessful	☐ Guided imagery	☐ Successful	☐ Unsuccessful
☐ Physical Therapy	☐ Successful	☐ Unsuccessful	☐ Medications	☐ Successful	☐ Unsuccessful
☐ TENS	☐ Successful	☐ Unsuccessful	☐ Nerve stimulator	☐ Successful	☐ Unsuccessful
☐ Implanted pump	☐ Successful	☐ Unsuccessful	☐ Pain Clinic	☐ Successful	☐ Unsuccessful
☐ Other_____				☐ Successful	☐ Unsuccessful

Pain Scale is with permission of VistaCare, Inc. Pain Scales (2004). www.vistacare.com

Boone Hospital Center
Columbia, Missouri

Adult Nursing Consults

4 3 Ø

Unit Secretaries: If the patient is admitted, enter the consults checked below. In the Comment section, type the reason for the consult.

Adult Nurse Consults				
	Yes	No	Comments	
Have you had a flu shot since October 1?			If yes, when?	☐ VACCINE
Have you ever had a pneumonia vaccine?			If yes, when?	
Do you have any problems that keep you from eating?			If yes, please explain:	☐ NUTRITION SERVICES CONSULT
Have you lost more than 10 pounds in the past 2 months?			If yes, are you dieting? ☐Yes ☐No	
Have you been diagnosed with diabetes within the past year?				
Have you had diarrhea & vomiting or poor intake within the past 3 days?				
Do you have any areas on your skin that are not healing?			☐ Skin Consult	
Are you currently receiving home health services?			Home Health for VAC dressing change	☐ SW CONSULT
Do you feel you will need additional help when you go home?			Will need assistance with wound VAC	
Do you need help for abuse?			Physical, emotional, sexual (circle)	
Were you in isolation the last time you were in the hospital?				☐ INFECTION PREVENTION CONSULT
Have you been exposed to tuberculosis (TB) recently?				
Have you had a positive TB skin test **and** have these symptoms right now: cough, fever, night sweats, unexplained weight loss, etc.?				
Have you had active TB in the past **and** have these symptoms right now: night sweats, unexplained wt. loss, cough, fevers, etc.?				
Do you have CJD (Creutzfeldt-Jakob Disease) or a family history of CJD?				
Do you use CPAP, BiPAP or a meter-dose inhaler (puffer)?			Which one?	☐ RT CONSULT

For Hospital Use Only - this area will be blank unless the patient is an inpatient.

The above consults were transcribed by US: _____ Date: _____ Time: _____

Nurse verification: _____ Date: _____ Time: _____

A physician signature is not required

Retain this form in the Physician Orders section of the medical record.