



ST. JOSEPH MERCY ANN ARBOR
 ___ Main ___ ASF ___ MOSC ___ OB ___ Angio ___ MRI

___ ST. JOSEPH MERCY SALINE
 ___ ST. JOSEPH MERCY LIVINGSTON
 ___ ST. JOSEPH MERCY BRIGHTON
 ___ ST. JOSEPH MERCY CANTON SURGERY CENTER

292166 / 00526 R 11/5/10 (M)

Name _____ Age _____ Date of Birth _____ Male ___ Female ___
 Phone [Hm] _____ [Wk] _____ [Cell] _____
 Name of Family Physician _____ City _____ Family Dr's Phone _____

The name I would like to be called is: _____ What is your occupation? _____

How do you learn best? (check all that apply): Reading Videos Groups Verbal Instruction Hands-On

If English is not your primary language, do you need the assistance of an interpreter? Yes No Language: _____

Do you need the assistance of a sign language interpreter? Yes No

Indicate the name of the person that information about your hospital stay may be released to: _____

Relationship: _____ Phone [Hm] _____ [Wk] _____ [Cell] _____

PREOPERATIVE HEALTH HISTORY	YES	NO	PREOPERATIVE HEALTH HISTORY	YES	NO	PREOPERATIVE HEALTH HISTORY	YES	NO
Chronic Cough or Lung Problems			Epilepsy/seizures - Date of last seizure			Skin problems (open wounds / rashes / shingles)		
Short of breath at rest			Chronic Back Problems			Circulation problems		
Short of breath after going up flight of stairs			Excess Bleeding from Surgery or Bleeding Disorders			Hard of hearing		
Recent cold, bronchitis or pneumonia			History of Anemia (low blood count)			Wear glasses / contact lenses		
History of Asthma or Wheezing			History of Deep Vein Thrombosis / Pulmonary Embolus			Problems walking		
Sleep Apnea <input type="checkbox"/> I have a CPAP machine			Diabetes, since _____			History of Cancer _____		
High Blood Pressure - how many yrs?			Liver Disease/Jaundice/Hepatitis			Chemotherapy last treatment date _____		
Heart Attack - Date			Kidney Disorder			Radiation therapy last treatment date _____		
Heart Failure - Date			Stomach Ulcer			Immunizations up to date		
Chest Discomfort / Tightness with exertion			Chronic Heartburn / GERD / Acid Reflux			History of motion sickness		
Irregular Heart Beat - Date			Hiatal Hernia			History of Mental Illness _____		
Mitral Valve Proplapse			Transfusion - Date			Are you on a special diet?		
Heart Murmur			Could you be pregnant			Do you have any problems with foods, chewing or swallowing?		
Muscle weaknesses or disorder			Last menstrual period - Date			Recreational Drugs		
Poor balance / history of falls			Are you breastfeeding			How often do you have a drink containing alcohol? <input type="checkbox"/> Never (0) <input type="checkbox"/> Monthly or less (1) <input type="checkbox"/> 2 to 4 times a month (2) <input type="checkbox"/> 2 to 3 times a week (3) <input type="checkbox"/> 4 or more times a week (4)		
<input type="checkbox"/> Stroke <input type="checkbox"/> TIA <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis			Dentures / bridges / caps			Years smoked _____ packs/day		
						Date stopped smoking		

An exam by a cardiologist (heart doctor) _____ If yes, Dr's Name _____ City _____ Year _____
 Heart Catheterization Angioplasty/stent _____ If yes, where _____ Year _____
 Exercise Stress Test _____ If yes, where _____ Year _____
 Ultrasound of Heart (Echocardiogram) _____ If yes, where _____ Year _____
 Pacemaker / ICD (Implantable Cardiac Defibrillator) _____ If yes, where _____ Year _____

Do you have any needs/concerns that may affect your care today: Yes No If yes, please check one of the following:
 fears cultural and/or religious beliefs unusual growth/development physical psychological Other - indicate in comments section

Comments: _____



PLEASE COMPLETE OTHER SIDE

PATIENT QUESTIONNAIRE



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Medications / Allergies / Height & Weight, refer to Medication Reconciliation Form

PLEASE LIST ALL PREVIOUS HOSPITALIZATIONS (surgery, childbirth, medical illness):

Date (approx. year)	Reason	Place (hospital or city)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Has your physician told you to take antibiotics before surgery and/or dental work? Yes No
- Have you had any serious problems with anesthesia? If so, what? Yes No
- Is there any family history of problems with anesthesia? Yes No
- Are there any personal/religious reasons you would refuse blood transfusions? Yes No
- Would you like to be seen by a clergy member? Yes No

Are you having pain related to your surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No Location: _____ Describe this pain: (check all that apply) <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing <input type="checkbox"/> Tingling <input type="checkbox"/> Shooting <input type="checkbox"/> Spasms <input type="checkbox"/> Intermittent <input type="checkbox"/> Continuous <input type="checkbox"/> Radiating <input type="checkbox"/> Other: _____ Rate level of pain (0-10) _____ (see below)	Do you have a history of chronic pain? <input type="checkbox"/> Yes <input type="checkbox"/> No Location: _____ Describe this pain: (check all that apply) <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing <input type="checkbox"/> Tingling <input type="checkbox"/> Shooting <input type="checkbox"/> Spasms <input type="checkbox"/> Intermittent <input type="checkbox"/> Continuous <input type="checkbox"/> Radiating <input type="checkbox"/> Other: _____ Rate level of pain (0-10) _____ (see below)
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Pain scale	No Pain	Moderate Pain						Worst Possible Pain			
	0	1	2	3	4	5	6	7	8	9	10

How do you manage your pain at home? _____

Do you need help in any of these activities? (Check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Bathing <input type="checkbox"/> Walking <input type="checkbox"/> Toileting <input type="checkbox"/> Dressing <input type="checkbox"/> Meals / Meal Preparation <input type="checkbox"/> Stair Climbing	Do you use equipment at home: (Check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Wheelchair <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Commode <input type="checkbox"/> Special Bed <input type="checkbox"/> Oxygen <input type="checkbox"/> Braces – Back / Leg / Arm <input type="checkbox"/> Other _____
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- Have you appointed a patient advocate for your health care? Yes No
- Name of patient advocate: _____
- Relationship: _____ Phone #: (_____) _____
- Would you like information on advance care planning and identifying a patient advocate? Yes No