Baptist Hospitals of Southeast Texas

Performing Sacred Work Every Day

Pre-Assessment Welcome

• The pre-assessment unit is located on the first floor in Day Surgery. When facing the front desk, it is at the end of the main mallway, to the left.

• You will first need to register at the information desk, and thereafter you will be seen by an admitting clerk.

• The pre-assessment clinic is open Monday thru Friday from 8:00am until 5:30pm, and is closed major holidays.

• During a pre-assessment appointment, patients will have a consultation with a pre-assessment nurse who will take a full medical history, fill our consent forms and make a list of your medications.

• It is important that all patients attending their pre-assessment appointment bring all their current medications or lists of medications including dosages, frequencies and purpose.

• If you have a living will (advance directives) or medical power of attorney, please bring a copy.

•If ordered and required by your surgeon, patients may need to also have their blood taken (Lab work) and a tracing of their heart rhythm (EKG).

• Patients may also be required to visit other departments to have further tests such as x-rays and ultrasound. Sometimes a pre-assessment appointment may last up to 2-3 hours. The length of time needed for your appointment will depend on your operation and what tests your surgeon requires you to have.

• You will have the opportunity to ask the nurses any question about your operation/procedure. It may be useful to write any questions down and bring them with you, as it can be easy to forget when you arrive.

• Finally if you have a need to bring a relative, friend, or an advocate for pre-operative assessment who can help you provide pertinent medical information or for support, feel free to do so.

• **For Day Surgeries (patients going home the same day):** Please ensure that you have arranged for someone to transport you home after surgery. You also need to arrange for a responsible adult to look after you at home for the first 24 hours after surgery, until the effects of the anesthetic or sedation you had for your surgery or procedure have worn off.

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Pre-Assessment Questionnaire

Name: _____ Date of Birth _____
Height: _____ Allergies/Reaction: _____
_____
_____
_____
Emergency Contact Name: _____
Relationship: _____ Phone: _____
Surgeon: _____ Surgery: _____
Surgery date/time: _____ Primary Care Physician: _____
Other doctors to notify: _____

Please check if applicable:

Neuro:

___ hearing problems ___ stroke ___ seizure ___ Alzheimer's
___ dizziness ___ blackouts ___ fainting
___ Neuropathy ___ Memory Loss ___ Organic Brain Syndrome
___ Dementia ___ TIA (mini stroke) ___ severe headache

Eyes:

___ vision problems ___ cataracts _____ Blind, if so, what eye?
___ glasses ___ contacts
___ Glaucoma ___ Macular Degeneration
Other: _____

Musculoskeletal:

___ Fractures, if so where/when? _____
___ Any pins/ metal/ screws? _____
___ Dislocations, if so where/when? _____
___ Carpal Tunnel Syndrome ___ neck problems ___ Rheumatoid Arthritis
___ Osteoarthritis ___ gouty arthritis
___ unspecified arthritis ___ back problems

Cardiovascular:

___ chest pain
___ irregular heartbeat
___ poor circulation
___ hypotension
___ ankle/leg swelling
___ aortic/mitral valve replacement
___ pacemaker
___ hypertension
___ angioplasty
___ arteriogram/angiogram
___ cardiomyopathy
___ congenital heart disease
___ heart attack
___ CHF (Congestion Heart Failure)
___ slow heart rate
___ CABG (bypass)
___ atrial fibrillation
___ murmur
___ mitral valve prolapsed
___ stents
___ fast heart rate
___ dizziness
___ defibrillator

Pulmonary:

___ Chronic Bronchitis
___ COPD
___ Asthma
___ Pneumonia
___ shortness of breath
___ Emphysema
___ Tuberculosis
___ Sleep Apnea

Endocrine:

___ hypoglycemia
___ Diabetes Type 1
___ hyperthyroid
___ New onset Diabetes
___ Diabetes Type 2
___ hypothyroid
___ current insulin pump
___ had insulin pump in the past

Gastrointestinal:

___ ulcer
___ Crohn's disease
___ acid reflux
___ ulcerative colitis
___ Hepatitis (Type __)
___ IBS
___ jaundice
___ hiatal hernia
___ hemorrhoids
___ rectal bleeding
___ chronic vomiting
___ colon polyps
___ chronic constipation
___ chronic nausea
___ chronic diarrhea
___ anorexia
___ bulimia
___ liver cirrhosis
___ ascites
___ gall stones
___ gallbladder problems

Genitourinary:

___ renal failure
___ recurrent UTI
___ frequency
___ hysterectomy
___ peritoneal dialysis
___ incontinence
___ enlarged prostate
___ hemodialysis
___ kidney stones
___ tubal ligation

Other:

___ blood transfusion
___ blood transfusion reaction
___ Exposure to chemical or occupational hazard; If so, what hazard? _____
___ Cancer; if so, where? _____
___ chemotherapy
___ radiation therapy
___ bleeding disorder
___ malignant hyperthermia
___ Do you smoke

If so how much and for how long? _____

Ongoing? Y or N

What did/do you smoke? _____

Have you quit smoking, if so when? _____

___ Do you drink alcohol?

If so, how much and how long? _____

What alcohol did you drink? _____

Have you quit drinking alcohol, if so when? _____

___ Drug abuse

If so, what kind and how long? _____

Ongoing? Y or N

What drugs do/did you use? _____

Have you quit abusing drugs, if so when? _____

Psychiatric History:

___ depression	___ suicide attempt	___ Post traumatic stress disorder
___ suicidal	___ alcohol abuse	___ counseling
___ drug abuse	___ ADD	___ claustrophobia
___ ADHD	___ Panic attacks	___ manic
___ anxiety	___ Bipolar	___ self mutilation
___ Schizophrenia	___ homicidal	

Family History: *(Patients parents or siblings only)*

___ Cancer, if so what kind? _____

___ Asthma	___ Hypertension	___ Diabetes
___ Stroke	___ Heart Disease	___ Unexplained death in family history

Allergy:

___ food ___ latex ___ dyes ___ tape/adhesives

Other allergies: _____

Domestic Violence:

___ Do you feel same from physical/mental abuse?

___ Have you been hit, kicked or slapped this year or last?

___ Do you know where to get help if you need it?

___ Have you been hurt by anyone in the last year?

___ Current suicide attempt

___ Current suicide ideations

Immunization:

___ Up to date on childhood immunizations

___ Unknown if you are up to date on childhood immunizations

___ Have you received a tetanus shot? If so, when? _____

___ Have you received a TB skin test? If so, when? _____

___ Have you received a flu shot? If so, when? _____

___ Have you received a pneumonia vaccine? If so, when? _____

Dental:

___ partial upper ___ partial lower ___ full upper dentures ___ full lower dentures

___ Is there anything in your mouth that comes off? _____

Devices at home:

___ glasses	___ contact lenses	___ cane
___ crutches	___ wheelchair	___ prosthesis
___ Oxygen equipment	___ CPAP/BIPAP machine	___ home vent

Advance directives/Living Will? Y or N

Does the hospital have a copy? Y or N

Medical Power of Attorney? Y or N

Does the hospital a copy? Y or N

Cultural:

Any spiritual, traditional, ethnic or cultural practices that need to be a part of your care?

_____

_____

_____

Chaplain:

Do you want our chaplain to notify your clergy/church of your admission? If so, what congregation?

_____

Any previous surgeries (date) or hospitalization (date)?

_____

_____

_____

_____

_____

_____

_____

_____

Anesthesia problems?

Medications (name, dosage, frequency, what for?) or provide list: