

**LEGACY SURGERY
CENTER OF FRISCO**

Pre-Admission Assessment

Patient Label

Date of Service: _____ Surgeon: _____

Scheduled Procedure: _____

Complaint: _____

Ht: _____ Wt: _____

- | | | | | | |
|------------------------------|-----------------------------|--------------------------------|------------------------------|-----------------------------|------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | HEART DISEASE | <input type="checkbox"/> Yes | <input type="checkbox"/> No | HEMATOLOGIC DISORDER |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | HYPERTENSION | <input type="checkbox"/> Yes | <input type="checkbox"/> No | (ANEMIA, SICKLE CELL) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | LUNG DISEASE | <input type="checkbox"/> Yes | <input type="checkbox"/> No | BLOOD BORN DISEASE |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | ASTHMA | <input type="checkbox"/> Yes | <input type="checkbox"/> No | GLAUCOMA |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | CANCER | <input type="checkbox"/> Yes | <input type="checkbox"/> No | ARTHRITIS |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | DIABETES | <input type="checkbox"/> Yes | <input type="checkbox"/> No | BLEEDING TENDENCIES |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | KIDNEY DISEASE/PROSTATE | | | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | GI PROBLEMS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | BACK PROBLEMS |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | SEIZURES | <input type="checkbox"/> Yes | <input type="checkbox"/> No | NEUROLOGICAL PROBLEMS |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | CORTISONE USE (2 YEARS) | | | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | SMOKER | | | |

HOW MUCH: _____

- Yes No **CONSUMES ALCOHOL**
FREQUENCY: DAILY WEEKLY MONTHLY FEW TIMES/YEAR NONE
 Yes No **PREGNANCY**

LMP: _____

- Yes No **SORE THROAT, COUGH, COLD**
 Yes No **THYROID DISEASE**
 Yes No **IMMUNIZATIONS UP TO DATE**

CULTURAL NEED: _____

OTHER: _____

PREVIOUS SURGERIES: _____

DRUG ALLERGIES: _____

FOOD ALLERGIES: _____

- Yes No **LATEX ALLERGIES**

LANGUAGE SPOKEN: _____

Outcome: Assesses risk for malignant hyperthermia
Assesses risk for anesthesia related problems

Do you have a history of motion sickness? Yes No

Have you experienced nausea or vomiting after anesthesia? Yes No

If yes, explain: _____

Pre-Admission Testing Ordered: N/A

CBC SMAC UA Chest X-ray EKG Pregnancy Test Other: _____

Pain Assessment Acute Chronic Both

Are you currently experiencing pain? Yes No

Onset date: _____ At Rest Only When Active

Describe location: Head Neck Upper Back

Lower Back Arm (Rt.) (Lt.)

Abdomen Leg (Rt.) (Lt.)

Other: _____

Frequency of Pain Constant Intermittent Occasionally

Daily Once a Week Once a Month N/A

Type of Pain N/A Burning Throbbing Sharp

Dull Shooting Stabbing Searing

Achy Cramping Tingling

Other: _____

Pain intensity: On a scale of one to ten, one being slight pain and five being moderate pain, ten being intolerable, rate your pain: _____

Does your pain affect any of the following?

Sleep Eating Daily activities such as walking Concentration

Thinking Describe other activities affected: _____

What makes pain worse: _____

How Is Pain Relieved? Medication Type: _____ Frequency Taken: _____

Rest Exercise Body Position

Herbs/Alternative Therapy Chiropractor or Other Professional

Outcomes:	Assesses psychosocial issues specific to the patient's medication management (I17) Identified cultural and value components related to pain (I61) Assess pain control (I16) Evaluates responses to pain management interventions (I54)
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Person Interviewed: _____

Relationship to a patient: Mother Father Legal Guardian
 Spouse Significant Other Other _____

Date of Interview: _____ Time: _____

Signature/Title of person conducting interview: _____