SDS6025-05

Wayne Memorial Hospital
Department of Nursing

PATIENT QUESTIONNAIRE

Your Name:_____ Height:____ Weight:____ TPR:_____B/P_____0_2SAT____
Birth Place:_____ Current township:_____
If retired, occupation prior to retirement:_____Maiden name_____ __
Medical physician:_____ Surgeon:_____
Name of Person to contact in case of emergency:_____
Business telephone:_____ Home telephone:_____
Allergies: (including food)_____
_____
Who will drive home?_____ Telephone:_____
(Please Note: two adults required for children 8 years of age and under)

Ambulatory Care Services **To be completed by patient prior to admission**

MEDICATIONS: (Please use extra sheet of paper if not enough spaces provided)

	Medication	Dose	Time Taken	Reason
1.				
2.				
3.				
4.				
5.				

MEDICAL INFORMATION: (Please circle **Y** for yes and **N** for no)

Are you under medical treatment now?	Y	N
Have you had any major operations? If yes, what?_____	Y	N
_____		
Have you had any serious or life threatening illness in the past?	Y	N
Have you ever had a head injury?	Y	N

Has a physician ever informed you that you or your child (if they are the patient) have any of the following:

Cardiac

➢ Heart murmur or heart disease	Y	N
➢ Chest pressure, pain on exertion	Y	N
➢ or severe shortness of breath on exertion	Y	N
➢ Aortic valve disease	Y	N
➢ Recent congestive heart failure	Y	N
➢ MI or heart attack within 1 year	Y	N
➢ Angioplasty, with or without stents	Y	N
➢ Pacemaker	Y	N
➢ High blood pressure	Y	N

Respiratory

➢ Shortness of breath	Y	N
➢ Chronic cough	Y	N
➢ asthma	Y	N
➢ Recent hospitalization or intubation or prednisone use for your breathing	Y	N
➢ Abnormal chest x-ray	Y	N
➢ Recent pneumonia	Y	N
➢ Sleep Apnea/CPAP @ home	Y	N

Diabetes

➢ Have you recently been hospitalized for glucose control	Y	N

Blood Disease

➢ History of Von Willebrand	Y	N
➢ Hemophilia	Y	N
➢ Do you bleed easily	Y	N
➢ Frequently take aspirin	Y	N
➢ History of bleeding after surgery	Y	N
➢ Have you ever had a blood transfusion?	Y	N
➢ Have you ever had a transfusion reaction?	Y	N

Have you had a pregnancy within the last three months	Y	N
Have you received rhogam	Y	N
Are you pregnant	Y	N

Last menstrual period_____
Last PAP_____
Last mammogram_____

Have you or your family members had a history of:

➢ Difficult intubation	Y	N
➢ Malignant hyperthermia	Y	N
➢ Prolonged hospital stay due to anesthesia	Y	N
➢ Nausea or vomiting post-op	Y	N
➢ Car sickness	Y	N
Difficult IV start	Y	N
Liver Disease	Y	N
Kidney Disease	Y	N

See Other Side

Affix Patient Label

Stomach or Intestinal Disease **Y N**

- Hiatal hernia **Y N**
- Ulcers **Y N**
- Frequent heartburn **Y N**
- Yellow jaundice or hepatitis **Y N**
- Convulsions or seizures **Y N**
  last seizure date_____
- Stroke **Y N**
- Neurologic problems **Y N**
- Recent stroke within one month **Y N**
- Recent onset of seizures within 6 mos **Y N**
- Change in frequency or treatment of seizures **Y N**

Tumor growths **Y N**
Malignancies **Y N**
Arthritis **Y N**
Prosthesis: ❒ glasses ❒ contacts ❒ artif. eye ❒ dentures ❒ artif. limb
Ambulation aids: ❒ crutches ❒ wheelchair ❒ cane ❒ walker

Who will assist you at home?_____

Do you smoke? **Y N**
If yes, how much_____

Do you drink alcohol? **Y N**
If yes, how much_____

Are you more than 50 lbs. overweight? **Y N**

Have you been exposed to a communicable disease in the last two weeks? chicken pox, measles, mumps, etc. **Y N**

Have you received the flu vaccine? **Y N**
When_____

Have you received the pheumovax? **Y N**
When_____

Are your immunizations up to date? **Y N**

Psyc/Soc

Have you ever been treated for depression or anxiety disorder? **Y N**

Are you especially worried about something now? **Y N**

Do you wish to speak with a social worker, substance abuse counselor, dietitian, or clergy person? (Please circle those that apply) **Y N**

Pain Assessment

Do you have pain? **Y N**

Pain Scale: **0 1 2 3 4 5 6 7 8 9 10**

How do you manage your pain?

_____

_____

Do you feel safe at home? **Y N**

Please complete for children

Is your child on a special diet? **Y N**
Does your child: ❒ breast feed ❒ feed self
❒ baby food ❒ bottle ❒ cup
❒ spoon ❒ need help ❒ table food
❒ type of formula_____
❒ how many oz. at a feeding_____

favorite food/drinks_____
favorite pastime_____
favorite toy or security object_____
How does your child take medications? _____
_____

Pain Assessment Codes - ask patient to rate their pain:_____

Comments:_____

_____

_____

Patient signature:_____ Date: _____/_____/_____ Time:_____ _____

Affix Patient Label

Wayne Memorial Hospital

Latex Sensitivity Screening Questionnaire

Please circle Yes or No for each of the following questions:

1. Have you ever been told by a doctor or other health care professional that you are allergic to latex? ..... **YES NO**

2. Have you ever experienced wheezing, runny nose, hives, itching, or redness of the skin after handling latex products such as rubber gloves, balloons, rubber bands, or condoms? ..... **YES NO**

3. Have you ever experienced wheezing, runny nose, hives, itching, or redness of the skin during a dental procedure or a rectal or vaginal exam? ..... **YES NO**

4. Do you have any food allergies, particularly to bananas, chestnuts, kiwi fruit, or avocados? ..... **YES NO**

5. Do you have any congenital abnormalities, such as spina bifida, neural tube defects, congenital urinary tract abnormalities or urologic (bladder or kidney) disorders? ..... **YES NO**

6. Are you now, or have you ever been, in an occupation in which you wore rubber gloves frequently? ..... **YES NO**

7. Do you or any members of your family have a history of asthma, dermatitis, eczema, hay fever, hives, or unexplained rashes? ..... **YES NO**

Completed by: _____ Date: _____

If not patient, relationship: _____

Source of information, if other than patient: _____
(Name/Relationship)

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Affix Patient Label