Baylor Orthopedic and Spine Hospital at Arlington

MEDICAL HISTORY

Date: _______________

Please check any problems you may have now or ever had in the past

☐ **High Blood Pressure***
☐ **Chest Pain / Angina***
☐ **Heart Disease / Heart Attack / CABG**
☐ **MVP/Heart Murmur***
☐ **Irregular Heartbeat***
☐ High cholesterol
☐ **Rheumatic Fever***
☐ **COPD/CHF***
☐ **Asthma*** ☐ Seasonal Allergies
☐ Tuberculosis
☐ **Emphysemia***
☐ Bronchitis
☐ Recent Flu or cold
☐ Chronic Cough
☐ Sleep Apnea ☐ w/ CPAP
☐ Thyroid Problems
☐ **Anemia***
☐ **Hemophilia***
☐ Blood Transfusion*
☐ **Hx. Of blood clots**
☐ **Bleed/Blood disorders***

☐ **Anticoagulants/blood thinners**
☐ **Bleed / Bruise easily***
☐ **Dementia***
☐ **Degenerative Brain Disorders****
☐ Migraine Headaches
☐ Psychiatric disorder
☐ Confusion / memory loss
☐ Abuse / Neglect issues
☐ Depression
☐ Anxiety
☐ **Suicide**
☐ Fainting ☐ Blackouts ☐ Ideation
☐ Seizures_________________
☐ Mutipule Sclerosis
☐ Stroke ☐ Paralysis
☐ **Recent fall*** / mobility issues
☐ Crutches ☐ Walker ☐ Cane
☐ Glasses/Contacts
☐ **Kidney Problems***
☐ Dialysis
☐ **Diabetes* IDDM / NIDDM**

☐ Closed head injury or L.O.C.
☐ Nerve Injury
☐ Back / Neck injury / Pain
☐ Herniated Disc
☐ **Steroid Use / Injections**
☐ Fibromyalgia
☐ Lupus
☐ Arthritis
☐ HIV / AIDS
☐ **Liver Problems***
☐ Hepatitis A, B, C
☐ Pancreatitis
☐ Hiatal Hernia / ulcer
☐ Acid Reflux / GERD
☐ Constipation
☐ Recent Nausia, vomiting, diarrhea
☐ Weight Loss/Gain. 10lbs.
☐ Hx: ☐ MRSA ☐ VRE **Recent Infection**
☐ Immunization current
☐ Current Skin Rash / Sore

☐ **Hx of organ transplant (s)****
☐ **Cancer***
☐ **Chemothrapy***
☐ **Radiation Therapy***
☐ Difficulty opening mouth
☐ Loose / chipped teeth
☐ Dentures / False teeth ↑↓
☐ Recent "toothache", abscess or dental problems
☐ Body piercing
☐ Hoarseness
☐ Hard of Hearing
☐ Hearing aid(s)
☐ Recreational drug use
Type________ amt__________
*☐ **Tobacco** use
_______ ppd______ yr(s)
Discussed Tobacco Cessation
☐ Alcohol use amt____________
☐ Hx of Nausia with Anesthesia
☐ Hx motion sickness

*** Refer to Anesthesia Guidelines for further testing**
**** Complete TSE Screening Tool**

Previous Non-surgicl Hospitalizations? ____

Any Other medical problems/conditions not listed above: ____

Significant Family Medical History: ____

Last Menstrual Period ________________________ ☐ **Primary Language** ____________________________ ☐ **Language-Line Needed for interpretation**

Surgical History

Surgery/ Implants	Date	Surgery/ Implants	Date

Any problems with previous surgery? **Yes/No** ____
Family or personal history of problems with anesthesia such as Malignant Hyperthermia demonstrated by high fever or cardiac arrest? **Yes/No**_________________________________

Pre-Admit Testing Vitals

Ht:_________ Wt:______
BMI: __________
Pain:: __________
Temp: _________
BP:_______/______
HR:_______SpO2%___

Emergency Contact/ Relationship to patient ____
Phone # ______________________________ Cell #___________________________ Work #_________________

Advanced Directive
Do you have an advanced directive? ☐ No ☐ Yes Please provide a copy for your chart. If "No" do you desire one? ☐ No ☐ Yes
Do you have a Durable Power of Attorney for Healthcare? ☐ No ☐ Yes Please provide a copy for your chart.
If Yes, who: ____ Phone #: ____________________________

Education
Concerns that may affect your learning? ☐ None ☐ Difficulty Reading ☐ Difficulty Hearing ☐ Memory loss ☐ Non-English Speaking
☐ English as a second language ☐ Other: ____
I learn best by: ☐ Printed material ☐ Verbal discussion ☐ Video ☐ Demonstration ☐ No Preference
Should anyone else be included in your teaching? ☐ No ☐ Yes Who:____

I have fully reviewed the above information and to the best of my knowledge, all information is complete and accurate. I understand that my answers could affect my anesthesia and outcome of my overall health experience.

Patient / Guardian Signature: ____ Date: __________________

Nurse Signature:____ Date:_________________

VMR-[CaseId]-520-1

NAME:**[PatientLast]**, **[PatientFirst]**
ACT#: **[PatientId]**
DOB: **[DOB]** AGE: **[Age]** SEX: **[Sex]**
DR: **[PhyLast]**, **[PhyFirst]**
ADMIT DATE: **[DOS]**

P A T O N L Y

ATYPICAL FINDINGS		ACTIONS TAKEN
☐ CXR	☐ BMI .50	☐ Results called/faxed to Surgeon________________
☐ EKG	☐ Latex Allergy	☐ Results called/faxed to Anesthesia_____________
☐ Labs	☐ History of M.H.	☐ EKG faxed to IM for interpretation______________
☐ **Critical Value**	☐ Poor Historian	☐ OR/Pre-op Director Notified____________________
☐ Other:______________________________		☐ See Nursing Notes (back of form)_______________

Reviewed and Updated

Nurse Signature:____Date:__________________

Nurse Signature:____ Date:__________________

Date / Time	Nurses Notes

VMR-[CaseId]-520-2

NAME:**[PatientLast]**, **[PatientFirst]**
ACT#: **[PatientId]**
DOB: **[DOB]** AGE: **[Age]** SEX: **[Sex]**
DR: **[PhyLast]**, **[PhyFirst]**
ADMIT DATE: **[DOS]**