***.***

***Columbus Community Hospital Anesthesia*** & ***Nursing Questionnaire***

***Directions: Please complete all areas and return it to hospital admissions clerk upon preadmission***

Patient name: Telephone number:

Age: Sex: Male Female Height: Weight: lbs.

Person to accompany patient home: Telephone number:

Do you have a living will? Yes No Medical Power of Attorney? Yes No

If yes on file at

Type of surgery or procedure: Surgeon:

Local pharmacy: Phone number: Please list all the medication you take on the attached medication list.

**Drug or food allergies:** None or list:

List all the operations you have had:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **MEDICATION HISIQRY** |  | **CABDIOVASCULAB** |
| Yes | No Have you had chemotherapy for cancer? | Yes | No High blood pressure |
| Yes | No Have you taken aspirin or aspirin | \*Yes | No Chest pain/pressure; last episode: |
|  | products or motrin in last 2 weeks? | \*Yes | No Irregular heart beat / Palpitations |
| Yes | No Have you taken steroids in the past 12 | Yes | No Pacemaker |
|  | months? | \*Yes | No Heart attack; When ? |
| Yes | No Are you taking birth control pills? | \*Yes | No Congestive heart failure; CHF |
| Yes | No Do you take herbs? St. John's Wort?  Ginkoba? Others? | \*Yes Yes | No Coronary artery disease No Elevated cholesterol |
|  | **ANESTHESIA HISTORY** | Yes | No Rheumatic fever |
| Yes | No Have you or any family members had any difficulty with anesthesia in the past? | Yes  \*Yes | No Murmur / Heart valve disease No Abnormal EKG |
|  |  | Yes | No Circulation problems; peripheral vascular disease |

Yes No Have any family members died or had a \*Yes No Sickle-Cell Anemia or trait

high temperature related to anesthesia? Yes No Blood clotting problems or bleeding disorders

#### RESPIRATORY LIVER

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Yes | No | Asthma |  | Yes | No Alcohol; frequency |
| Yes | No | Emphysema |  | Yes | No Street drugs; |
| Yes | No | Bronchitis; date of last episode |  | Yes | No Hepatitis; liver disease, yellow jaundice |
| Yes | No | Pneumonia; date of last episode |  |  | **GASIBQINIESIINAL** |
| Yes | No | Shortness of breath |  | Yes | No Ulcer / Rectal bleeding |
| Yes | No | Recent cold or respiratory infection |  | Yes | No Nausea/ vomiting; within last 2 wks |
| Yes | No | COPD (Chronic Lung Disease) |  | Yes | No Abdominal pain |
| Yes Yes | No No | Tuberculosis  Smoker; pks/day for | yrs | Yes Yes | No Chronic heart burn / reflux / GERD / Hiatal hernia No Unexplained weight loss in the past six months |
| Yes | No | Dip or chew tobacco |  | Yes | No Poor nutrition (unbalanced diet) |

**MUSC!JLQ-SKELETAL**

|  |  |  |
| --- | --- | --- |
| Yes | No | Osteoarthritis arthritis; degenerative |
| Yes | No | Rheumatoid arthritis |
| Yes | No | Low back pain |
| Yes | No | Metal implants or artificial joints |

***(Continue on page 2)***

***SPOS*** • ***1-800-874-9621* ANESTHESIA** & **NURSING PREOPERATIVE ASSESSMENT**

## CUESTIONARIO DE ANESTESIA Y CUIDADO DE LOS ENFERMOS

**COLUMBUS CQMMUNIIY HOSPITAL**

*Direcciones: Por favor complete todas areas y devuelvalo al empleado de admision de! hospital al tiempo de preadmision.*

Nombre de paciente: Numcro de telefono:

Edad: Sexo: Hombre Mujer Estatura: Peso: libras Persona quien va a acompanar el/la paciente a casa: Numero de telefono:

l,Tiene un testamento en vida?

Si

No Poder Medico? \_ \_ Si No

Si es asi: en los archivos de Tipo de cirugia o procedimiento: Cirujano:

Escriba una lista de medicina que usted toma en la hoja de medicaci6n adjunta.

Farmacia: Nfunero de telefono:

Alergias a drogas o comida: Ningun 0 Escriba una lista: Escriba una lista de todos tipos de operaciones que usted ha tenido:

**Historia de M!.ldil:imi CacclionscuJac**

Si No Usted ha recibido quimioterapia para Si No Presion sanguinea alta

cancer? \* Si No Dolor del pecho/presion, ultimo episodio Si No Usted ha tornado aspirina o productos de

aspirina o motrin en las ultimas dos \* Si No Latido irregular del corazon / palpitaciones semanas? Si No Marcapasos (estabilizador del ritmo cardiaco)

Si No Usted ha tornado esteroide en los pasados \* Si No Ataque cardiaco; cuando doce meses? \* Si No Insuficiencia cardiaca congestiva; CHF

Si No Usted esta tomando medicina para \*Si No Enfermedad de arteria coronaria control de la natalidad? Si No Colesterol elevado o colesterol alto

Si No Usted toma yerbas? St. John's Wort? Si No Fiebre reumatica

Ginkoba? Otras? Si No Sonido anormal del corazon / enfermedad de la

**Histurili ,11': Ancstc:.ia** valvula del corazon

\* Si No Electrocardiograma anormal

|  |  |  |
| --- | --- | --- |
| Si | No | Usted o algun miembro familiar ha tenido |
|  |  | cualquier dificultad con |
|  |  | anestesia en el pasado? |
| Si | No | Ha muerto algun familiar o ha tenido una |
|  |  | temperatura alta relacionada a la |
|  |  | anestesia? |
| **Rci,ipirnts.1rio** | | |
| Si | No | Asma |
| Si | No | Enfisema |
| Si | No | Bronquitis; fecha del ultimo episodio |
| Si | No | Pulmonia; fecha del ultimo episodio |
| Si | No | Falta de respiracion |
| Si | No | Catarro reciente o infeccion respiratorio |
| Si | No | COPD (Chronic Lung Disease= |
|  |  | Enfermedad cronico de los pulmones) |
| Si | No | Tuberculosis |
| Si | No | Fumador paquetes al dia por |
|  |  | anos |
| Si | No | Inmersion o mastique tabaco |

Si No Problemas con circulacion; enfermedad del vascular periferico

\* Si No Anemia de globulos *I* falciformes

Si No Problemas con propiedad de coagulacion de sangre o desordenes sangramientos

# Higado

Si No Alcohol; frecuencia Si No Drogas i leg aJe s:

Si No Hepatitis; enfermedad del higado; ictericia amarilla

# Gastrointcsl inal

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Si  **Si** | No  No | Ulcera; sangramiento del recto  Nausea; vomitando dentro de las ultimas dos |
|  |  | semanas |
| Si | No | Dolor abdominal |
| Si | No | Acedia cronica / reflujo / GERD / hernia atraves |
|  |  | del hiato esofagico del diafragma |
| Si | No | Baja de peso inexplicada en los ultimos seis |
| Si | No | meses  Mala nutricion / alimentacion (dieta no balanceada) |
| **Mn,<;c1d1a:sq ut l1•t** it:!> | | | |
| Si | | No | Osteoartritis artritis; degenerativo |
| Si | | No | Artritis reumatoidea |
| Si | | No | Dolor bajo de la espalda |
| Si | | No | implantes metales o coyunturas artificiales  **(Continue al otro lado)** |

**EVALUACION DE ANESTESIA Y CUIDADO PREOPERATONO**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NEURO** | | | **MISCELLA EQUS** | | |
| Yes | No | Multiple Sclerosis | Yes | No | Hearing aids |
| Yes | No | Stroke; When: | Yes | No | Glasses / Contacts |

**ENDQCRl I;**

|  |  |  |
| --- | --- | --- |
| Yes Yes Yes Yes | No No No No | TIA's  Migraine headaches Seizure; date of last episode Loss of consciousness |
| Yes | No | Muscle weakness *I* Paralysis |
| Yes | No | Fainting episode |
| Yes | No | Myasthenia Gravis |

Yes No Diabetes

Yes No Thyroid disease

Yes No Other endocrine (hormone) disorders

**Dl; TAL HARDWARE** (Circle all that apply)

Yes No Capped teeth / Bridges / Braces / Retainer Yes No Dentures; Upper/ Lower *I* Partial

|  |  |  |
| --- | --- | --- |
| **L** | | |
| Yes | No | Kidney disease |
| Yes | No | Kidney stones |
| Yes | No | Dialysis |
| Yes | No | Urinary retention |
| Yes  **Any** | No  **other** | Urinary frequency  **medical problems not listed:** |

Yes No Chipped / Cracked *I* Loose / Missing

**EEMALI; PATIENTS**

Yes No Are you pregnant? (or possibly)

Date of last menstrual period: Postmenopausal

**X Date: Signature of person completing this form: Relationship to patient: Self Spouse Parent**

0 Surgery Room

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| [ ] | Preop Med | D | Positioning | O | CasUDressing | [J | Supplemental Oxygen |
| D | Preop Scrub | D | Monitoring | 0 | PACU | O | Drains, Foley, NGT |
| 0 | NPO | O | IVline | D | Cough & Deep Breath | D | Discharge from PACU |

O Other

**Nurse's Signature\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Date \_**

**ANESTHESIA** & **NURSING PHYSICAL ASSESSMENT/ PREOP COUNSELING**

**BP p R T SpO** % **Pt Id:** Dverbal DID Band

**MENTAL STATUS RESPIRATORY CARDIOVASCULAR GASTROINTESTINAL SOCIAL**

0 Oriented D Clear; bilateral D Regular Olrregular Bowel sounds D Live alone

D Awake Rales; OMurmur D Present 0 Absent D Live with family D Calm RUL RML ALL LUL LLL Radial pulse present: **ABDOMEN** D Nursing home D Apprehensive Rhonchi; [J Left QRight 0 Non-distended **ADMITTED**

D Confused RUL RML ALL LUL LLL Pedal pulse present: D Distended D Ambulatory

0 Unresponsive D Left ORight 0 Non-tender 0 Wheelchair

D Uncooperative 0Tender D Stretcher

**NPO since: IV:\_ \_ \_** Ga., **Site** L R

**Advanced Directive Information:** O G!ven lJ Declined Comments:

**Nurse's Signature Date** Time

1 **Planned Anesthetic/ Special Monitors:** (circle) A-line, EDM, Central line 1-\_Al\_rw\_a"""y'\_:

F.R\_.o\_ \_M.\_.\_,\_,.. R\_.o\_.M\_.

M\_. P\_.\_1 \_ 11\_ \_11\_ 1 \_

2 Risks, benefits, procedures, and alternatives of planned anesthetic care

3 discussed with patient and/or parent or guardian.

4

5 Plan accepted for **General/ Spinal** / **Epidural/ Axillary/ lnterscalene** /

E. **T.I.V.A.** / **IV Regional/ M.A.C.** / **Postop Pain Management/**

**Comments: Date** & **Time of Last Dose:**

0 BETA BLOCKER YES NO

D Preoperative assessment reviewed with patient.- - - - - - - - -

CRNA

EKG

Hgb / Hct / Pit

PT

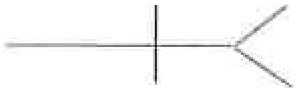
PTI

POSTANESTHESIA ASSESSMENT

### D

INR

Other

CXR

**Evaluator Signature: Date: Time:**

History and physical reviewed and updated. For topical ophthalmiccases only. \_ \_ \_

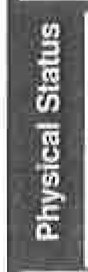
**Signed Date:**

**Addressograph**

Patient without complaint and no apparent post anesthetic sequelae

[] See Progress notes

**Signed Date:**



***Anesthesia*** & ***Nursing Preoperative Assessment*** *(* ***page 2)***

SPOS · 1-800-874-!1621 Rflv 1-1.'i

Nmru

Si No

Si No

Si No

Esclerosis multiple Apoplejia; cuando\_ \_ TIA's

\_ \_ \_

\_ \_ \_

\_ \_ 1

Miscclanio

Si No

Si No

< **iFln ,•r in n**

Audifono / aparato de audicion/oido Lentes (anteojos) / lentes de contactos

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Si No

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Si No

### &nal

Si No

Si No

Si No

Si No

Si No

Dolor de cabeza mignma

Ataque repentino; fecha del ultimo episodio

Perdida del conocimiento

Debilidad de los musculos; paralisis Episodios de desmayo

Miastenia grave

Enfermedad de los rinones Piedras renales / en los rinones Dialisis

Retencion urinaria Frecuencia urinaria

Si No Diabetes

Si No Enfermedad de la glandula tiroides

Si No Otros desordenes endocrinos (hormona)

Aparatos Dcntalcs (Circule todos aplicables)

Si No Dicntcs con coronas/ pucnte dental/ frenos / retenedor

Si No Denturas: alto bajo parcial

Si No Dientes quebrados / sueltos *I* desmolados

**Pacientes quc** son Mujcrcs

Si No Esta embarazada? (Hay la posibilidad?)

Fecha de! ultimo menstruacion\_ \_ \_ \_ \_ \_ \_ \_ Po tmenopausia

Cualquier otro problema medico que no esta en la lista: **X** Fecha :

Fim1a de persona completando esta forma:

Relacion al paciente: si mismo sp sota) padres

**FOR HOSPITAL STAFF USE ONLY- PREOPTEACHING**

D Preop Med D Preop Scrub D NPO

D Surgery Room

0 Positioning D Monitoring D IV line

D Other

D Cast/Dressing

0 PACU

0 Cough & Deep Breath Nurse's Signature

D Supplemental Oxygen D Drains, Foley, NGT D Discharge from PACU

Date

**BP p**

**MENTAL STATUS**

D Oriented

D Awake

D Calm

D Apprehensive

D Confused

D Unresponsive

D Uncooperative

**ANESTHESIA** & **NURSING PHYSICAL ASSESSMENT/ PREOP COUNSELING**

**R T SpO** % **Ptld: OVerbal** DID **Band RESPIRATORY CARDIOVASCULAR GASTROINTESTINAL SOCIAL**

D Clear; bilateral 0 Regular O Irregular Bowel sounds 0 Live alone

Rales; 0 Murmur 0 Present 0 Absent 0 Live with family RUL RML RLL LUL LLL Radial pulse present: **ABDOMEN** 0 Nursing home

Rhonchi; 0 Left D Right D Non-distended **ADMITTED**

RUL RML RLL LUL LLL Pedal pulse present: D Distended D Ambulatory

D Left D Right D Non-tender D Wheelchair

OTender LJ Stretcher

NPO since: **IV: Ga. , Site LR**

**Advanced Directive Information:** OGiven 0 Declined

Comments:

**Nurse's Signature**

**Planned Anesthetic/ Special Monitors:** (circle) A-line, EDM, Central line

1. Risks, benefits, procedures, and alternatives of planned anesthetic care
2. discussed with patient and/or parent or guardian.

4

**Plan accepted for General** / **Spinal** / **Epidural/ Axillary** / **Interscalene** /

**Date Time**

**Airway:** F.R.O.M. / R.O.M. M.P. I II Ill IV

EKG CXR

Hgb / Hct / Pit I-<

E. **TJ.V.A.** / **IV Regional/ M.A.C.** / **Postop Pain Management/**

**Comments:**

0 BETA BLOCKER YES NO

D Preoperative assessment reviewed with patient.

**Date** & **Time of Last Dose:**

PT INR

PTI Other

#### POSTANESTI-IESIA ASSESSMENT

**- - - - - - - - - - - - - - - - -**CA**-**NA**- - - - - - - - - - - - -a** D Patient without complaint and no apparent post

**Evaluator Signature: Date: Time:** anesthetic sequelae.

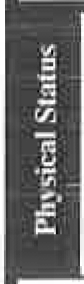
1story and physical reviewe and updated. For topical ophthalmic cases on y.

**Signed Date:**

D See Progress notes.

Signed Date:

**Addressograph** .



#### EVALUACION DE ANESTESIA Y CUIDADO

**PREOPERATONO**

COLUMUJJS COMMUNO'Y HOSPITAL

COLUMBUS COMMUNITY HOSPITAL

MEDICATION LIST

TO HELP US BETTER PLAN YOUR CARE; PLEASE LIST ALL MEDICATIONS YOU TAKE DAILY, INCLUDING HERBAL SUPPLEMENTS AND VITAMINS.

|  |  |  |
| --- | --- | --- |
| MEDICATION | DOSAGE/STRENGTH | WHEN TAKEN |
|  |  |  |
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