THE JOHNS HOPKINS HOSPITAL
PATIENT HISTORY
PREOPERATIVE CENTER

for addressograph plate

Today's Date: _____

Gray areas indicate minimal data elements

Pateient Information

PATIENT INSTRUCTIONS: This questionnaire helps the physicians and nurses evaluate your health and plan your care. Please answer all the questions using a PEN. Indicate with a check mark or write your answer in the space provided. Bring completed form with you and/or complete on the day of admission/treatment.

NAME OF PERSON FILLING OUT THIS FORM: _____ **RELATIONSHIP TO PATIENT:** _____

Name: _____ Age: _____
Your Telephone Number: _____ Weight: _____ Height: _____
Contact person in case of emergency: _____
Contact person's telephone number: _____ Relationship: _____
Type of Surgery: _____ Surgeon: _____
Do you have any medical problems different from the reason you are here today? ☐No ☐Yes
Who is your family doctor? _____
Are there any cultural/religious/family beliefs or values we should be aware of in planning/providing your care?
☐ No ☐ Yes (explain) _____
Do you have an Advance Directive? ☐No ☐Yes (specify) _____
Last menstrual period: _____ N/A Is there any possibility of pregnancy at this time? ☐No ☐Yes
We know that violence is a problem for many people, so we routinely screen all patients for abuse or violence in their lives, is this a problem for you in any way? ☐No ☐Yes Do you want help with this today? ☐No ☐Yes

Dietary

Have you had an unexplained loss or gain of weight recently? ☐No ☐Yes (describe) _____
Are you on a special or restricted diet? ☐No ☐Yes (describe) _____
Do you have any problems with swallowing? ☐No ☐Yes (describe) _____

Functional Status

Do you wear or have: (Check all that apply)

☐Removable dentures
☐Partial ☐Full ☐Upper Lower
☐Hearing aid Right Left
☐Glasses
☐Contact lenses
☐Infusion Catheter Type:
☐ False Eye ☐Right ☐Left
☐ Colostomy
☐Ileostomy
☐Indwelling bladder catheter
☐ Artificial Limb (Describe:)
☐ None of these apply

Self Care

How have you managed these activities during the past year?

	Independent	Need Assistance	Comments:
Feeding	☐	☐	
Walking	☐	☐	
Bathing	☐	☐	
Dressing	☐	☐	
Meal Preparation	☐	☐	
Toileting	☐	☐	
Transportation	☐	☐	

Patient Name: _____ History Number: _____

Discharge Planning

What special equipment or home services are you using now or have you used in the past 12 months?

- ☐ Cane
- ☐ Crutches
- ☐ Wheelchair
- ☐ Walker
- ☐ Hospital Bed
- ☐ High-Rise Toilet Seat
- ☐ Commode
- ☐ Oxygen
- ☐ Phone Amplifier or TDD
- ☐ Glucose Meter
- ☐ Housekeeper
- ☐ Companion / Sitter (Specify provider) _____
- ☐ Home Health Aide (Specify provider) _____
- ☐ Visiting Nurse (Specify provider) _____
- ☐ Meals on Wheels

Do you have a preferred home care agency? ☐ No ☐ Yes (specify) _____

Other Community Services: _____

Other special equipment or devices used at home: _____

☐ None of these apply

Who provides care for you at home? ☐ Self ☐ Other: _____

Medications

Please list all the medicines you currently take (including non-prescription medicines)

Name of Medicine	How Much (Dosage)	How Often	Name of Medicine	How Much (Dosage)	How Often

In the past 12 months Have you had any difficulty getting prescriptions filled? ☐ No ☐ Yes

If yes, check all that apply:

☐ Financial Need ☐ Availability ☐ Other: (describe) _____

Smoking/ Alcohol

Do you use any other drugs not listed above? ☐ No ☐ Yes What drugs? _____

Do you smoke? ☐ No ☐ Yes ☐ Cigarettes ☐ Cigars ☐ Pipe Amount smoked daily: _____

Have you smoked in the past? ☐ No ☐ Yes Year quit: _____

Do you drink alcohol? ☐ No ☐ Yes How much each day? ☐ Beer ☐ Wine ☐ Liquor

Allergies

Are you allergic to any medicines? ☐ No ☐ Yes (specify) _____

What kind of reaction do you have?

Are you allergic to any foods? ☐ No ☐ Yes (specify) _____

Are you allergic to latex? ☐ No ☐ Yes (specify) _____

Are you allergic to dyes used for x-rays? ☐ No ☐ Yes (specify) _____

Are you allergic to iodine or seafood? ☐ No ☐ Yes (specify) _____

Any other allergies? ☐ No ☐ Yes (specify) _____

PATIENTS: Please continue with NEXT PAGE →

VALUABLES and SIGNATURES sections to be completed by MEDICAL STAFF ONLY.

Valuables

	Location 1					Locatio n 2					Locations 3					Location 4				
Unit																				
Date																				
Initials																				
DISPOSITION CODES: H = Home BS = Bedside S=Security US = Unit Storage																				
	None	H	BS	S	US	None	H	BS	S	US	None	H	BS	S	US	None	H	BS	S	US
Clothing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Money/Jewelry	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dentures/Partials	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glasses/Contacts	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heating Aide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Prosthesis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medications	☐	☐	■	☐	☐	☐	☐	■	☐	☐	☐	☐	■	☐	☐	☐	☐	■	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Signatures

Validation Signatures/Titles	Time	Date	Validation Signatures/Titles	Time	Date

Patient Name:_____ History Number:_____

Medical History

PATIENTS PLEASE CONTINUE: Check all that apply to you now, or have applied to you in the past.

Describe your exercise tolerance

☐ Bedridden ☐ Able to walk with assistance ☐ Active (over 2 flights of steps or comparable with ease)
☐ Limited (less than 1 flight of steps)
☐ Moderate (1 - 2 flights of steps or comparable) ☐ Regular exercise

Heart Disease

☐ High Blood Pressure ☐ On medication for high blood pressure
☐ Chest Pain ☐ With activity ☐ At rest
☐ Chest Pain combined with: ☐ difficulty breathing ☐ sweatiness ☐ nauseated feeling
☐ Heart attack Date:_____ Give name of hospital where treated:_____
☐ History of heart attacks in your immediate family (parents, brothers, or sisters)
☐ Heart surgery or angioplasty
Date:_____ Give name of hospital where treated:_____
☐ Heart rhythm problem or palpitations ☐ Pacemaker Last Checked:_____
☐ Heart valve problem or congenital abnormality. Describe:_____

Special Heart Testing: (Please bring all NON-JOHNS HOPKINS medical reports with you.)

☐ Exercise stress test Date:_____ Hospital/Dr:_____
☐ Echocardiogram Date:_____ Hospital/Dr:_____
☐ Thallium Date:_____ Hospital/Dr:_____
☐ Cardiac catheterization Date:_____ Hospital/Dr:_____
☐ Electrocardiogram (EKG) Date:_____ Hospital/Dr:_____

Lung Disease

☐ Asthma/Wheezing ☐ Bronchitis ☐ Emphysema ☐ Cystic Fibrosis ☐ Sleep Apnea
☐ Lung Cancer ☐ Tuberculosis ☐ Other:_____

Regarding the above lung problems, have you ..... (Check all that apply)

☐ been on steroids (prednisone, medrol, or cortisone) within past 2 years? When?_____
☐ been admitted to the hospital within past 2 years? When?_____
☐ been seen in an Emergency Room within past 2 years? When?_____
☐ been on antibiotics within past 6 months? When?_____
☐ had a chest x-ray within the last 6 months? (Bring all NON-JOHNS HOPKINS reports with you)
Where?_____ When?_____
☐ undergone breathing tests? (Bring all NON-JOHNS HOPKINS reports with you)
Where?_____ When?_____

Other Medical Conditions

☐ Kidney disease
☐ Dialysis ☐ Transplant
☐ Bladder/Urinary disorder (infections)
☐ Adrenal disease
☐ Stomach ulcers
☐ Diabetes
☐ Insulin ☐ Pills ☐ Diet Controlled
☐ Thyroid ☐ on Thyroid medication
☐ Fainting spells
☐ Neurologic disease
☐ Parkinsons Disease
☐ Seizures ☐ on medication for seizures
☐ Stroke When?_____
☐ Hiatal Hernia
☐ Unable to lie flat without heartburn

Patlent Name:_____ History Number:_____

Medical History (continued)

Other Medical Conditions (continued from previous page)

- ☐ Sickle Cell
- ☐ Excessive Bleeding (dental work, easy bruising)
  Describe:_____
- ☐ Family history of Excessive Bleeding
- ☐ Blood Clots (Legs or Lungs) when:_____
- ☐ Blood Transfusion within last three months
- ☐ Neuromuscular Disease
  Describe:_____
- ☐ Arthritis: Jaw Neck Other joints
- ☐ Liver disease
  - ☐ Hepatitis (yellow jaundice) when?_____
  - ☐ Other liver disease?_____
- ☐ Back Problems
  - ☐Neck ☐ Thoracic ☐Low back
  - ☐Previous back injury
  - ☐Previous back surgery
- ☐ Now taking blood thinners (coumadin, heparin)
- ☐ Taking asparin or asparin containg medications within the last week
- ☐ Taken anti-inflammatory medicines in the past 4 days (Motrin-like products)
- ☐ + HIV
- ☐ Cancer (type):_____
- ☐ Recent cold or flu (within 4 weeks)
- ☐ Any other illness (specify):_____

Anesthesia / Surgical History

Do you refuse blood transfusions? ☐No ☐Yes
Have you donated your own blood for **THIS** operation? ☐No ☐Yes
Have you ever had general anesthesia (put to sleep) for an operation before? ☐No ☐Yes
Have you ever had a spinal or epidural before? ☐No ☐Yes
Were there any problems with either of the above procedures? (Include drug reactions) ☐No ☐Yes
If yes, describe:_____

Please list all past operations or hospital stays

Reason	Year	Check here if you were admitted to Intensive Care
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐

FOR HOSPITAL STAFF ONLY:

_____ Validation Signature/Title

_____ Date