CAMPBELL COUNTY MEMORIAL HOSPITAL
501 SOUTH BURMA AVENUE
GILLETTE, WYOMING 82716

PRE-PROCEDURE AND ADMISSION SCREENINGS

Name: ______________________ Age: ________ ☐ Male ☐ Female

Home phone: ____________ Work: ____________ Local/cell number: ____________

Would it be best to call you at: ☐ home ☐ work Can we leave a message? ☐ Yes ☐ No

Cardiovascular

Are you now or have you ever been treated for:

- Heart trouble: ________ ☐ Yes ☐ No
- Heart murmur: ________ ☐ Yes ☐ No
- Heart attack: ________ ☐ Yes ☐ No
- Angina/chest pain: ________ ☐ Yes ☐ No
- An irregular pulse: ________ ☐ Yes ☐ No
- Congestive heart failure: ________ ☐ Yes ☐ No
- Pacemaker / internal defibrillator ________ ☐ Yes ☐ No
  - Type / Model of pacemaker: ________
  - Are you under the care of a heart doctor? ☐ Yes ☐ No
  - Name: ________ ☐ Yes ☐ No
  - Phone #: ________ ☐ Yes ☐ No
- Blood Pressure: ☐ High or ☐ Low ☐ N/A ☐ Yes ☐ No
- Do you have a bleeding or clotting problem ________ ☐ Yes ☐ No
- Instructed to stop blood thinners: ________ ☐ Yes ☐ No
  - When: ________
- EKG in the last 3 months: ☐ Yes ☐ No Date: ________
- Dr. ________
- Comments: ________

Respiratory

Do you have now, or have you ever had:

- Breathing or lung problems: ________ ☐ Yes ☐ No
- Asthma: ________ ☐ Yes ☐ No
- Bronchitis : ________ ☐ Yes ☐ No
- Emphysema: ☐ Yes ☐ No COPD: ________ ☐ Yes ☐ No
- Tuberculosis: ________ ☐ Yes ☐ No
- Have you ever been told you have sleep apnea: ________ ☐ Yes ☐ No
- Routine oxygen use: ________ ☐ Yes ☐ No
- CPAP ________ BiPAP ________
- Do you smoke or chew tobacco: ________ ☐ Yes ☐ No
- # packs/day: ________ How long: ________ ☐ Quit: ________
- # cans/week: ________ How long: ________ ☐ Quit: ________

Are you able to complete the following tasks without being short of breath?

- Walking around the house: ________ ☐ Yes ☐ No
- Climbing a flight of stairs: ________ ☐ Yes ☐ No
- Recent cold or productive cough ☐ Yes ☐ No
- Comments: ________

GI / GU

Do you have now, or ever had, intestinal or stomach problems:

- Ulcers: ________ ☐ Yes ☐ No
- GERD / Reflux: ________ ☐ Yes ☐ No
- Bowel problems: ________ ☐ Yes ☐ No
- Hiatal hernia : ________ ☐ Yes ☐ No
- Other: ________
- Liver problems: ________ ☐ Yes ☐ No
- Jaundice: ________ ☐ Yes ☐ No
- Hepatitis: ________ ☐ Yes ☐ No
- Other: ________
- Kidney problems: ________ ☐ Yes ☐ No
- Are you pregnant: ________ ☐ Yes ☐ No
- Comments: ________

Neurological

Are now, or have you ever been treated for:

- Head Injury: ________ ☐ Yes ☐ No
- Seizures/Convulsions: ________ ☐ Yes ☐ No
- Blackout spells: ________ ☐ Yes ☐ No
- Stroke: ________ ☐ Yes ☐ No
- TIA ("mini stroke") ________ ☐ Yes ☐ No
- Severe headaches: ________ ☐ Yes ☐ No
- Comments: ________

Musculoskeletal / Skin

Do you have:

- Muscle or joint pain: ________ ☐ Yes ☐ No
- Back trouble: ________ ☐ Yes ☐ No
- Arthritis: ________ ☐ Yes ☐ No
- Limited joint movement: ________ ☐ Yes ☐ No
- Do you have chronic pain: ________ ☐ Yes ☐ No
- Do you have any open wounds: ________ ☐ Yes ☐ No
- Comments: ________

Endocrine

Do you have:

- Diabetes: ________ ☐ Yes ☐ No
- Diet controlled: ________ ☐ Yes ☐ No
- Oral diabetic medications: ________ ☐ Yes ☐ No
- Insulin: ☐ Yes ☐ No Type: ________ Dosage: ________
- Thyroid disease: ________ ☐ Yes ☐ No
- Autoimmune diagnosis: ☐ Yes ☐ No
  - Chronic/long-term steroid use in last year? ☐ Yes ☐ No
- Comments: ________

Allergies / Reactions

- Are you allergic to anything: ________ ☐ Yes ☐ No
- If yes, to what: ________
- type of reaction: ________
- Do you have an allergy to latex? ________ ☐ Yes ☐ No
- Describe: ________
- Have you or anyone in your family had problems with general anesthesia? ________ ☐ Yes ☐ No
- If yes, describe ☐ you ☐ family member ________

Immunizations / Exposures

- Are routine immunizations current: ________ ☐ Yes ☐ No
- Is your tetanus up-to-date: ________ ☐ Yes ☐ No
- Date of Tetanus: ________ ☐ Yes ☐ No
- Date of flu vaccine: ________ ☐ Yes ☐ No
- Date of Pneumonia vaccine: ________ ☐ Yes ☐ No
- Have you ever been told you have an infection that is resistant to antibiotics? ☐ Yes ☐ No
- If yes, ☐ MRSA ☐ VRE ☐ Other: ________ ☐ Don't know
- Do you currently have an infectious disease? ☐ Yes ☐ No
- Explain: ________

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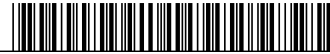

Previous Surgeries			
Date	**Type of Surgery**	**Date**	**Type of Surgery**

Current Home Medications
(Include prescriptions, herbals, over-the-counter drugs, inhalers, patches, pumps, etc.)

Medication Name	**Dose** (Strength or Concentration)	**Route** (By Mouth, Injection, etc.)	**Frequency** How many times a day do you take this?	**Indication** Why are you taking this?

Have you ever or are you currently using recreational drugs? ☐ Yes ☐ No Comments:

Do you drink alcohol? ☐ Yes ☐ No How much ____________________ How long? ____________

ADL's / Self Care

Hearing aid: ______ ☐ Yes ☐ No	Normal mobility: ______ ☐ Yes ☐ No	Requires assistance with: ☐ Yes ☐ No	Any learning or developmental:
Glasses: ______ ☐ Yes ☐ No	Crutches: ______ ☐ Yes ☐ No	Dressing: ______ ☐ Yes ☐ No	disabilities: ______ ☐ Yes ☐ No
Contact lenses: ______ ☐ Yes ☐ No	Walker: ______ ☐ Yes ☐ No	Sitting: ______ ☐ Yes ☐ No	If yes, explain: ______
Comments: ______	Wheelchair: ______ ☐ Yes ☐ No	Transferring: ______ ☐ Yes ☐ No	______
______	Non-ambulatory: ______ ☐ Yes ☐ No	Comments: ______	______

Psychological / Social

Religious or Cultural beliefs which may affect treatment or care:	Do you have Advanced Directives? ☐ Yes ☐ No or Living Will? ☐ Yes ☐ No
	Primary Language:

Nurse Notes – DO NOT WRITE BELOW THIS LINE

Preop Medication instructions given: ☐ Yes ☐ No ☐ N/A Who is your medical doctor?

☐ Instructed not to smoke or chew tobacco 12 hrs prior to surgery.

Instructed to remove all body piercing? ☐ Yes ☐ No ☐ N/A

Ht: ____________ Wt: ____________kg

The above information has been reviewed and verified with the patient.

Reviewing Nurse's Signature: Date / Time:

Patient's Signature: Date / Time: