PREADMISSION DATA

FRAN - (814) 255-6781 EXT. 126
(814) 255-6251

H&P APPOINTMENT DATE_____
DOCTORS OFFICE FIRST THEN PRE-TESTING AT HOSPITAL

Please bring a list of ALL your MEDICATIONS, VITAMINS, & SUPPLEMENTS with you to your H&P Appointment

PLEASE FILL OUT BOTH SIDES OF THIS FORM IN DETAIL AND BRING WITH YOU FOR THE ABOVE APPOINTMENT

NAME _____

DATE OF BIRTH _____ AGE _____

MARITAL STATUS ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Occupation _____

If retired, what was your occupation? _____

Preferred pharmacy: _____

Pharmacy address: _____

Name of Family Physician _____

Date of Last Visit _____

The following will be filled out in the office:

Type of Surgery: _____

Date of Surgery: _____

Admitting Physician: _____

Hospital _____

MEDICAL HISTORY: *Do you have, or have you ever had, the following conditions? Please check all that apply.*

- ❑ Diabetes
- ❑ Pneumonia/Bronchitis
- ❑ Tuberculosis
- ❑ High Blood Pressure
- ❑ Heart Disease
  - ❑ Heart Stent
  - ❑ Heart Surgery
  - ❑ Heart Attack
- ❑ Peripheral vascular/arterial disease
- ❑ Anxiety/Depression
- ❑ Blood Clots (DVT/PE)
- ❑ Cancer/Type: _____
- ❑ Anemia (low blood count)
- ❑ Stomach Ulcers
- ❑ Enlarged Prostate
- ❑ Color Blindness
- ❑ COPD/Asthma
- ❑ HIV
- ❑ Hepatitis
- ❑ Stroke
- ❑ Seizure
- ❑ Kidney Disease
- ❑ Urinary tract infection
- ❑ Other: _____

HOSPITALIZATIONS & SURGERIES: *(Include all since birth: Females please include childbirth)*

YEAR	REASON	HOSPITAL	YEAR	REASON	HOSPITAL

MEDICATIONS: *(Please list all medications you are currently taking or bring a current list with you. Please be specific, including aspirin and all over the counter medications.)*

MEDICATION	DOSE	HOW OFTEN	MEDICATION	DOSE	HOW OFTEN

ALLERGIES: *(List all allergies to medication, tapes, iodine and foods)*

_____

_____

SOCIAL HISTORY:

Are you on a restricted diet? ❒ Yes ❒ No If yes, describe diet: _____

Do you now smoke, or have you smoked in the past? ❒ Yes ❒ No Year Quit___

If YES, how many packs per day?_____ How many years? _____

Do you chew tobacco? ❒ Yes ❒ No How much? _____ How many years? _____

Do you drink alcohol? (circle one) NEVER RARELY SOCIAL MODERATELY EXCESSIVELY

Do you have a Drug/Substance/Alcohol addiction? ❒ Yes ❒ No

Have you ever been treated for a Drug/Substance/Alcohol addiction? ❒ Yes ❒ No

If yes, describe treatment _____

FEMALES: Date of last menstrual period: _____ Are you pregnant? ❒ Yes ❒ No

Is there a chance you could be pregnant? ❒ Yes ❒ No

HOME SITUATION: ❒ I live alone ❒ I have help at home / Who? _____

❒ I have more than 5 steps/stairs ❒ I can stay on one floor

FAMILY HISTORY: *HAVE ANY OF YOUR BLOOD RELATIVES (Mother, Father, Brother, Sister, Grandparents) EVER HAD ANY OF THE FOLLOWING CONDITIONS?*

(IF YES, Please write the relationship on the blank line after the condition.)

CONDITION			Relationship to You	CONDITION			Relationship to You
Heart Disease	❒ Yes	❒ No	_____	Kidney Disease	❒ Yes	❒ No	_____
Heart Attack	❒ Yes	❒ No	_____	Thyroid Disease	❒ Yes	❒ No	_____
Seizures	❒ Yes	❒ No	_____	Arthritis	❒ Yes	❒ No	_____
Strokes	❒ Yes	❒ No	_____	Cancer (give type)	❒ Yes	❒ No	_____
Hypertension	❒ Yes	❒ No	_____	_____			
Diabetes (sugar)	❒ Yes	❒ No	_____	Bleeding Disorder	❒ Yes	❒ No	_____

REVIEW OF SYSTEMS: *Do you currently have any of the following symptoms? Please check all that apply.*

❒ Denture use	❒ Burning with urination	❒ Dizziness
❒ Difficulty swallowing	❒ Frequent urination (day or night)	❒ Headache
❒ Hoarseness/recent voice change	❒ Blood in urine	❒ Easy bruising
❒ Shortness of breath	❒ Black tarry stools/blood in stools	❒ Fever/chills
❒ Frequent Cough	❒ Vomiting blood	❒ Skin wounds
❒ Coughing up blood	❒ Frequent nosebleeds	❒ Sore or loose teeth
❒ Chest pain	❒ Sinus problems	❒ Change in weight

PAIN MANAGEMENT: Are you currently under the care of a Pain Management Physician? ❒ Yes ❒ No

If yes, name of physician: _____ For what condition: _____