Ascension Seton

Preoperative Dashboard*PLEASE FAX FORM TO 512-324-3415 OR EMAIL BACK WITH "-PHI-" IN SUBJECT LINE PRIOR TO YOUR APPT***
pshclinic@ascension.org

Please arrive at least 30 minutes prior to your appointment time to complete the registration process

Health History

Name:_____ **Date of Birth:**_____

Phone #:_____ **Height:**_____ **Weight**:_____

Who will assist you at home after surgery?_____**Relationship**_____

What procedure are you currently getting ready for?_____

Surgeon's name_____

Surgical date_____**Surgical Location**_____**PSH Appt. Date**_____

Who is your Primary Care Physician? (Name and location):_____

Do you see any specialty physicians (cardiology, endocrinology, etc)? (Name and location):

_____

RISK ASSESSMENT			
Are you able to walk: ☐ 2 blocks or more ☐ 1-2 blocks ☐ Housebound (most of the time)	Which gait do you use (more often than not)? ☐ None ☐ Single-point stock (cane) ☐ Crutches/Walker ☐ Wheelchair	Do you use community supports (home help, meals-on-wheels, district nurse)? ☐ None or 1 per week ☐ Two or more per week	Will you live with someone who can care for you after your operation? ☐ Yes ☐ No

ANESTHESIA			
Have you had anesthesia?			Y N
Are you willing to receive blood/blood products in the event of an emergency?			Y N
Have you or a family member experience any of the following:	Self	Family	Details
High temperature caused by anesthesia			
Slow to regain muscle movement (Pseudocholinesterase Deficiency)			
Severe nausea/vomiting after anesthesia			
Difficulty with intubation			
Prolonged confusion after anesthesia			
Significant change in blood pressure			

Motion sickness			

SOCIAL HISTORY		
Do you use nicotine? If yes: cigarettes cigars chewing tobacco How many and how often? _____	Y	N
Are you a former Smoker?	Y	N
If yes: How long, when did you quit and how many cigarettes did you smoke? _____		

E-CIGARETTE/VAPING

☐ Never ☐ Use, within last 90 days ☐ Former use, more than 90 days ago

Type:

☐ Cannabinoid Infused ☐ Flavored only ☐ Nicotine Infused ☐ Other: _____

Frequency:

☐ 1-25 inhales/day ☐ 51+ inhales/day ☐ ½ cartridge/day ☐ 2 cartridges/day

☐ 26-50 inhales/day ☐ ¼ cartidge/day ☐ 1 cartridge/day ☐ Other: _____

ALCOHOL		
Do you drink alcohol?	Y	N

***If yes,* what type?** ☐ Beer ☐ Wine ☐ Liquor ☐ Other:_____

How often? ☐ 1-2 times per year ☐ 1-2 times per month ☐ 1-2 times per week ☐ 3-5 times per week

☐ Daily ☐ Several times per day ☐ Several times per day ☐ Other: _____

How many drinks do you have on a typical day when you do drink?

☐ 1-2 drinks/day ☐ 3-4 drinks/day ☐ 5-6 drinks/day ☐ 7-9 drinks/day ☐ Greater than 10 drinks per day

SUBSTANCE ABUSE		
Do you use any recreational street drugs?	Y	N

If yes, which of the following:

☐ Amphetamines ☐ Heroin ☐ Methamphetamines

☐ Cocaine ☐ Inhalants/Glues/Solvents ☐ Prescription Medications

☐ Ecstasy ☐ Marijuana ☐ Other: _____

☐ Hallucinogens/LSD ☐ Methamphetamines

How Often?

☐ 1-2 times per year ☐ Daily ☐ 1-2 times per week

☐ 1-2 times per month ☐ Several times per day ☐ Other: _____		
Do you have steps in your home? *If yes,* how many?_____	Y	N
Do you live in a two story home?	Y	N
If yes, are you able to stay on the first floor after surgery?	Y	N
Do you wear glasses/contacts?	Y	N
Hearing aids?	Y	N
Dentures?	Y	N

WORK HISTORY

Are you currently:

☐ Employed ☐ Retired ☐ Disbabled ☐ Unemployed

DEPRESSION		
Do you have little interest or pleasure in doing routine activities?	Y	N
Are you having feelings of feeling down, depressed, or hopeless?	Y	N
Are you taking medication to control or treat depression?	Y	N

GAD ANXIETY DISORDER		
Do you feel nervous, anxious, or on edge?	Y	N
Are you unable to control or stop your worrying?	Y	N
Are you taking medication to control anxiety?	Y	N

SUICIDE RISK SCREENING AND ASSESMENT		
Have you ever attempted suicide in your lifetime? *If yes,* when:_____	Y	N

DIET

☐ Regular ☐ Low Cholesterol ☐ Mechanical Soft ☐ Tube Feeding

☐ Bland ☐ Low Carb ☐ No Added Salt ☐ Vegetarian

☐ Diabetic ☐ Low Fat ☐ Pureed ☐ Other: _____

☐ Kosher ☐ Low Sodium ☐ Renal

Medical History

CARDIAC HISTORY		
Congestive Heart Failure	Y	N
Heart Attack *If yes*, when: _____	Y	N
Chest Pain	Y	N
Heart Murmur	Y	N
Hypertension (High Blood Pressure)	Y	N
Palpitations	Y	N
Atrial Fibrillation	Y	N
Shortness of Breath	Y	N
Cardiac Stents	Y	N
Pacemaker	Y	N
Artificial Valve	Y	N
Defibrillator or ICD	Y	N
Pulmonary Hypertension	Y	N
Blood Clots *If yes*, DVT or PE	Y	N
High Cholesterol or Hyperlipidemia	Y	N
RESPIRATORY HISTORY		
COPD	Y	N
Asthma	Y	N
Pulmonary Fibrosis	Y	N
Cystic Fibrosis	Y	N
Any recent cough?	Y	N
Other:		
Sleep Apnea ***If yes***, do you use: CPAP, BiPAP, VPap or None	Y	N
If ***no*** please answer the following questions:		

Do you snore loud enough to wake up others through a closed door?	Y	N
Do you feel tired during the day or fall asleep in conversation?	Y	N
Has anyone observed you stop breathing or gasp for air during your sleep?	Y	N

KIDNEY DISEASE		
Chronic kidney disease *If yes,* what stage_____	Y	N
Receive dialysis for kidney disease	Y	N
Benign Prostatic Hyperplasia	Y	N
LIVER DISEASE		
Chronic Hepatitis	Y	N
Cirrhosis	Y	N
Liver Failure	Y	N
Fatty Liver	Y	N
NERVOUS SYSTEM DISORDERS		
Stroke	Y	N
Transient ischemic attack (TIA)	Y	N
Brain aneurysm	Y	N
Alzheimer's	Y	N
Dementia	Y	N
Parkinson's	Y	N
Seizures	Y	N
Multiple Sclerosis	Y	N
Brain tumor	Y	N
MUSCLE DISORDERS		
Osteoarthritis	Y	N

Myasthenia Gravis	Y	N
Muscular Dystrophy	Y	N
Osteoporosis	Y	N
Fibromyalgia	Y	N
BLOOD DISORDERS		
Hemophilia	Y	N
Von Willebrand Disease	Y	N
Factor II, V, VII, X or XII deficiency	Y	N
Iron deficient anemia	Y	N
Sickle Cell Anemia	Y	N
Thalassemia	Y	N
Have you ever had an organ transplant	Y	N

ENDOCRINE DISORDERS			
Diabetes		Y	N
Pre-diabetes		Y	N
Thyroid Disease		Y	N
CANCER			
Cancer	*If yes,* what kind _____ Currently being treated?_____	Y	N

Integrity/skin		
Psoriasis	Y	N
Eczema	Y	N
Other - please list		
Immunology		
AIDS	Y	N
HIV Infection	Y	N
Lupus	Y	N

Rheumatoid Arthritis - If yes, who is your Rheumatologist?_____	Y	N
Other - please list	Y	N
Psychiatric		
Bipolar	Y	N
Other - please list		

FAMILY HISTORY	
Please provide family health history (heart, lungs, cancer, GI, endocrine, etc)	
	Medical Problems
Father	
Mother	
Grandfather	
Grandmother	
Brother	
Sister	
Daughter	
Son	
Uncle	
Aunt	

SURGICAL HISTORY	
	DATE

ALLERGIES	
Please list allergies:	☐ No Known Drug Allergies
Drug/Food Name	**Reaction**
Latex (balloons, gloves, condoms) ☐ Yes ☐ No	
Adhesive ☐ Yes ☐ No	

MEDICATIONS		
Pharmacy name and location:		
Please list all prescription medications		
NAME	**DOSE**	**FREQUENCY**

Narcotics ***PLEASE LIST ACTUAL NUMBER OF TIMES NARCOTICS ARE TAKEN *PER DAY**** NAME	DOSE	FREQUENCY

Supplements, Vitamins, and Over-the-Counter medications NAME	DOSE	FREQUENCY