NAME: _____

DOB: _____

Gwinnett Hospital System

PLACE LABEL HERE

SURGERY ADMISSION DATABASE

INFORMATION OBTAINED FROM: ❑ Patient ❑ Family ❑ Other_____

Reason for Coming to Hospital: _____ *Physician/Surgeon:* _____

Primary Care Doctor (Family Doctor): _____ *Doctors Phone number:* _____

Primary Language **(if other than English)** _____ **Do you speak and understand English well?** ❑Y ❑ N

(If interpreter or language line used, RN to document name of Interpreter or language line operator number)

Height _____ft _____inches **Weight:** Stated or estimated _____lbs. * **Actual** _____kg **BMI** _____ 💻 (if ≥35)

Unintentional Weight loss of 10 pounds or more in the last month: ❑ Yes ❑ No 💻 * **We will calculate for you**

- **TB Screening:**

Check all that apply:	**(# for nurse use) *Without explanation**
❑ Cough lasting more than 2 weeks	(3)*
❑ Coughing up blood	(5)*
❑ Fever or chills or night sweats	(2)*
❑ Lost over 10 pounds without reason in the last 6 months	(2)*
❑ HIV positive	(2)
❑ History of TB	(2)
❑ Exposure to TB in the past 2 years	(4)
❑ In jail or prison in the past 2 years	(2)
❑ Homeless or in a shelter in the past 2 years	(2)
❑ Born in another country AND in the USA less than 5 years	(1)
❑ Travel to Asia, Africa, Latin America, Eastern Europe in the past 2 Years	(1)
❑ None of the Above	

For RN to complete:

TB Screening Score=

- **Ebola Screening: RN complete the Ebola Virus screening form.**

- **Sleep Apnea Screening:**

Have you been told that you snore loudly? ❑ Yes ❑ No

Do you often feel tired, fatigued, or sleepy during the day? ❑ Yes ❑ No

Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep? ❑ Yes ❑ No

Do you have high blood pressure or on medication to control high blood pressure? ❑ Yes ❑ No

Is your body mass index 35 or greater? ❑ Yes ❑ No *Nurse will calculate for you*

Are you 50 years old or older? ❑ Yes ❑ No

Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches? ❑ Yes ❑ No

Are you a male? ❑ Yes ❑ No

For RN to complete:

OSA Scoring Criteria –If score is 0-4, pt is NOT considered moderate to high risk OSA.

❑ ***Moderate to High Risk for OSA (Yes to 5 to 8 questions)--Place Sleep Apnea Orders #21266 on chart***

❑ **Diagnosed History of OSA—Place Sleep Apnea Orders #21266 on chart.**

❑ **Pt is 20 weeks gestation or greater not located in GWP. Place on OSA precautions and place Sleep Apnea Orders #21266 on chart.**

Smoking: Have you ever smoked? ❑ **Yes** ❑ **No** **Do you still smoke?** ____, **if no, what year did you quit?** ____

How many packs per day? ____ **How many years have or did you smoke?** _____ ❑ Information to quit requested 💻

💻 **ALLERGIES:** ❑ **None** Type: ❑ Drug ❑ Dye (X-ray) ❑ Food ❑ Latex ❑ Other

(If you have more than 3 allergies, please give list to RN)

List : _____ Reaction: _____

List: _____ Reaction: _____

List: _____ Reaction: _____

Previous Blood Transfusion: ❑ **Yes** ❑ **No** Transfusion reaction ❑ **Yes** ❑ **No** _____

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PAST SURGERIES: Type and Year: _____ ❑ NONE

_____

_____

_____

Anesthesia Complications: ❑ Self ❑ Family Describe: _____ ❑ NONE

Please include: nausea, vomiting, malignant hyperthermia, or problems with placement of a breathing tube

MEDICAL HISTORY

Yes	No			Yes	No			Yes	No		
❑	❑	High Blood Pressure	Cardiovascular	❑	❑	Kidney Insufficiency	Kidney/Bladder	❑	❑	Diabetes : controlled by ❑ Diet ❑ Pill ❑ Insulin ❑ Pump	Endocrine
❑	❑	Heart Failure (fluid in lungs)		❑	❑	Kidney Failure					
❑	❑	Angina/Chest Pain		❑	❑	Dialysis Type : _____					
❑	❑	Heart Attack: Year _____		❑	❑	Kidney stones		❑	❑	Steroid use in past 6 months	
❑	❑	Heart Valve/Rheumatic fever, Murmur		❑	❑	Prostate Enlargement					
				❑	❑	Difficulty Urinating		❑	❑	Thyroid or Goiter Disease	
❑	❑	Pacemaker/Defibrillator		❑	❑	Chronic Urinary Catheter		❑	❑	Hormonal Disorder	
❑	❑	Ablation/Stent/Bypass surgery		❑	❑	Ileal Conduit		❑	❑	Females: Last Menstrual Period _____ ❑ Menopause (>1 year) ❑ Pregnant ❑ Breastfeeding	Females
❑	❑	Abnormal EKG		❑	❑	Back/Hip/Knee /Neck problems	Musculoskeletal				
❑	❑	Blood clotting problems/DVT									
❑	❑	Varicose Veins		❑	❑	Arthritis					
❑	❑	Anemia		❑	❑	History of Falls					
❑	❑	Sickle cell		❑	❑	**Most Strenuous exercise tolerated** ❑ light housework ❑ climb stairs ❑ exercise strenuously		❑	❑	Depression	Psych.
❑	❑	Asthma/Emphysema	Respiratory					❑	❑	Bipolar Disorder	
❑	❑	Abnormal Chest x-ray						❑	❑	Anxiety Disorder	
❑	❑	Recent cold/fever/productive cough						❑	❑	Schizophrenia	
								❑	❑	Other: _____	
❑	❑	Shortness of breath/COPD		❑	❑	TPN/Tube feedings	Gastrointestinal				
❑	❑	Pneumonia/Bronchitis		❑	❑	Colostomy/Ileostomy		❑	❑	Lupus	Immune/Exposure/Other
❑	❑	Blood clot in lung		❑	❑	Hiatal hernia/ Acid Reflux		❑	❑	MRSA/VRE	
❑	❑	Home Oxygen use ___ L		❑	❑	Ulcer/Colitis/Crohns		❑	❑	HIV/AIDS	
❑	❑	Stroke/Brain Injury	Neurologic	❑	❑	Jaundice/Cirrhosis					
❑	❑	Area Affected: _____		❑	❑	Hepatitis : type _____		❑	❑	Cataracts/Glaucoma	
❑	❑	Seizures/Epilepsy		❑	❑	Swallowing or choking problems		❑	❑	Loose teeth/Caps/Crowns	
❑	❑	Spina Bifida/Polio						❑	❑	TMJ/jaw	
❑	❑	Headaches/Migraines		❑	❑	Cancer Type: _____ Treatment: _____ _____		❑	❑	Other Medical Problems: _____ _____ _____	
❑	❑	Sinus Problems									
❑	❑	Muscle Weakness/disease									
❑	❑	Motion Sickness									
❑	❑	Chronic Back Pain									

LIST CURRENT PRESCRIPTION MEDICINES/INHALERS/OVER-THE-COUNTER MEDICINES (include ASPIRIN) AND/OR HERBAL AND NUTRITIONAL SUPPLEMENTS): ❑ NONE

If you have a printed list of your home medicines with you, write "SEE LIST" and give copy of list to RN.

Medicine/Supplement Dose & frequency	Last Dose	Medicine/Supplement Dose & frequency	Last Dose

Have you received the pneumonia vaccination (pneumovax) in the last 5 years? ❑ Yes (Date) _____ ❑No ❑Unsure

Have you received the influenza vaccine (flu shot) this flu season? ❑ Yes (Date) _____ ❑No ❑Unsure

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SKIN: ❑ No problems ❑ Wound ❑ Sore ❑ Rash ❑ Other: _____

PAIN: ❑ YES ❑ NO Scale (0 – 10) _____ ❑ Constant ❑ Intermittent How Long? _____
Location: _____ Treatment/Medicines: _____
❑ Pain Pump Relief ❑ Yes ❑ No

VASCULAR ACCESS: ❑ PORT ❑ PICC ❑ Dialysis Access Date last flushed _____ ❑ NONE

ASSISTIVE DEVICES:
❑ Eye Glasses (with you ❑ Yes ❑ No) ❑ Contacts ❑ Dentures/Bridges (with you ❑ Yes ❑ No)
❑ Hearing aids (with you ❑ Yes ❑ No) ❑ Implants/Prosthesis (with you ❑ Yes ❑ No)
❑ Cane ❑ Walker ❑ Wheelchair ❑ Crutches ❑ NONE

SOCIAL/SPIRITUAL/CULTURAL:
Occupation: _____ ❑ Retired ❑ Other: _____
How do you learn best? ❑ Verbal/Listening ❑ Written/Reading ❑ Demonstration ❑ No Preference
Any Communication needs or religious/spiritual/cultural beliefs that will affect your care? ❑ Yes ❑ No
Explain: _____
Alcohol use: ❑ None Type (amount/frequency _____ Last Drink _____
Recreational drugs: ❑ None Type (amount/frequency) _____
Do you have any body piercing jewelry? ❑ Yes ❑ No Location: _____
Do you feel safe returning home? ❑ Yes ❑ No Explain: _____
Do you feel that you have been abused, neglected, or exploited by someone close to you? ❑ Yes ❑ No
Explain: _____
Do you want a hospital chaplain to visit? ❑ Yes ❑ No Religious Preference: _____

DISCHARGE PLAN: Who will bring you to the hospital? _____ Phone # _____
Patient Phone #'s Home: _____ Cell: _____ Other: _____
Who will drive you home and/or care for you after you go home? _____
Who would we contact in case of emergency? _____ Phone # _____
Current living situation: ❑ With spouse or Significant other ❑ With Relative/friend ❑ Lives Alone
❑ Assisted Living ❑ Nursing Home ❑ Other _____
Do you require assistance with: ❑ feeding ❑ bathing ❑ toileting

For inpatient ONLY - RN to complete: **(If one or more checked, obtain Physician Order)** ❑ NONE
Do you have any new onset of: ❑ Difficulty swallowing ❑ Difficulty feeding/bathing/toileting ❑ Difficulty mobility ❑ Falls

LIFE PLANNING: Designated decision maker: ❑ DPOA-HC ❑ Next of Kin ❑ Patient's verbal request
Name: _____ Phone: _____
Advance Directive : ❑ DPOA-HC ❑ Living Will ❑ **None** ❑ Obtain chart copy ❑ Information requested
Code Status: ❑Full Code ❑DNR/AND ❑DNI Order on chart: ❑Y ❑N

ADMISSION DATA BASE REVIEWED BY: _____ RN Date/Time: _____ / _____
_____ RN Date/Time: _____ /

Inpatient Referral Required or may be needed if applicable
Inpatient Referrals Completed _____ **Date/Time:** _____ / _____