Gwinnett Surgery Center, LLC

PLACE LABEL HERE

SURGERY ADMISSION DATABASE

Information Obtained From: ❑ Patient ❑ Family ❑ Other: _____

Reason for Coming to the Surgery Center: _____ Surgeon: _____

Primary Care Doctor (Family Doctor): _____ Doctor's phone number: _____

Primary Language **(if other than English):** _____ **Do you speak and understand English well?** ❑ Yes ❑ No

Height: _____ ft ____ inches **Weight:** Stated or estimated _____ lbs. *__Actual__ _____ kg **BMI** _____

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

Sleep Apnea Screen:

Do you have sleep apnea? ❑ Yes ❑ No Do you use CPAP/BiPAP? ❑ Yes ❑ No

Sleep Problems: ❑ **None** ❑ Excessive daytime sleepiness ❑ Loud snoring ❑ Long pauses during sleep

__If BMI ≥ 35 AND one sleep problem checked, follow sleep apnea guidelines per policy.__

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

How many packs per day? ____ How many years have or did you smoke? _____

ALLERGIES: ❑ **None** Type: ❑ Drug ❑ Dye (X-Ray) ❑ Food ❑ LATEX ❑ Other

(if you have more than 3 allergies, please give list to nurse)

List: _____ Reaction: _____

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List: _____ Reaction: _____

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

PAST SURGERIES: ❑ **None** Type and Year: _____

_____

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	❑	❑	TPN/Tube feedings	Gastrointestinal
❑	❑	Heart Failure (fluid in lungs)		❑	❑	Kidney Failure		❑	❑	Colostomy/Ileostomy	
❑	❑	Angina/Chest Pain		❑	❑	Dialysis Type: _____		❑	❑	Hiatal hernia/Acid Reflux	
❑	❑	Heart Attack: Year _____		❑	❑	Kidney Stones		❑	❑	Ulcer/Colitis/Crohns	
❑	❑	Heart Valve/Rheumatic fever		❑	❑	Prostate Enlargement		❑	❑	Jaundice/Cirrhosis	
❑	❑	Murmur, Irregular heart beat		❑	❑	Difficulty Urinating		❑	❑	Hepatitis Type: _____	
❑	❑	Pacemaker/Defibrillator		❑	❑	Chronic Urinary Catheter		❑	❑	Swallowing Difficulty	
❑	❑	Ablation/Stent/Bypass Surgery		❑	❑	Ileal Conduit		❑	❑	Diabetes - Controlled by: ❑ Diet ❑ Pill ❑ Insulin ❑ Pump	Endocrine
❑	❑	Abnormal EKG		❑	❑	Stroke/Brain Injury Area Affected: _____	Neurologic	❑	❑	Steroid use in past 6 mo.	
❑	❑	Blood clotting problems/DVT		❑	❑	Seizures/Epilepsy		❑	❑	Thyroid or Goiter Disease	
❑	❑	Varicose Veins		❑	❑	Spina Bifida/Polio		❑	❑	Hormonal Disorder	
❑	❑	Anemia		❑	❑	Headaches/Migraines		❑	❑	Females: Last Menstrual Period _____ ❑ Menopause (> 1 year) ❑ Pregnant ❑ Breastfeeding	Females
❑	❑	Sickle cell				Sinus Problems					
❑	❑	Asthma/Emphysema	Respiratory	❑	❑	Muscle Weakness/Disease					
❑	❑	Abnormal Chest X-Ray		❑	❑	Motion Sickness					
❑	❑	Recent cold/fever/ productive cough		❑	❑	Chronic Back Pain					
❑	❑	Shortness of breath/COPD				**Musculoskeletal:**		❑	❑	Depression	Psych.
❑	❑	Pneumonia/Bronchitis		❑	❑	Back/Hip/Knee/Neck Problems		❑	❑	Bipolar Disorder	
❑	❑	Home Oxygen use ____ L		❑	❑	Arthritis		❑	❑	Anxiety Disorder	
❑	❑	Blood clot in lung		❑	❑	History of Falls		❑	❑	Schizophrenia	
		Immune/Exposure:		❑	❑	**Most Strenuous Exercise Tolerated - Able to tolerate:**		❑	❑	Other: _____	
❑	❑	Lupus				❑ Light housework		❑	❑	Other Medical Problems:	
❑	❑	MRSA/VRE				❑ Climb stairs					
❑	❑	HIV/AIDS				❑ Exercise strenuously					
❑	❑	Cataracts/Glaucoma	Other								
❑	❑	Loose teeth/Caps/Crowns		❑	❑	Cancer Type: _____					
❑	❑	TMJ/Jaw Problems				Treatment:					

SURGERY ADMISSION DATABASE

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 a copy of the list to the nurse.

Medicine/Supplement Dose & Frequency	Last Dose	Medicine/Supplement Dose & Frequency	Last Dose

Have you received the pneumonia vaccine (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

TB SCREEN: ❑ **NO HISTORY OF TUBERCULOSIS**
OR HAVE YOU HAD: ❑ Fever ❑ Night Sweats ❑ Unexplained Weight Loss ❑ Coughing Blood
❑ Have you had a new cough for more than 3 weeks? **(If 2 or more checked, notify Infection Control Nurse)**

SKIN: ❑ No Problems ❑ Wound ❑ Sore ❑ Rash ❑ Other:

PAIN: ❑ Yes ❑ No Scale (0-10) _____ ❑ Constant ❑ Intermittent How Long? _____
Location: _____ Treatments/Medicines: _____
❑ Pain Pump Relief after use of treatments/medicines: ❑ 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 ❑ Other: _____ ❑ **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: _____

DISCHARGE PLAN: Who will bring you to the surgery center? _____ 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 an 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

Admission Database Reviewed By: RN Signature/Date/Time:
RN Signature/Date/Time:
RN Signature/Date/Time: