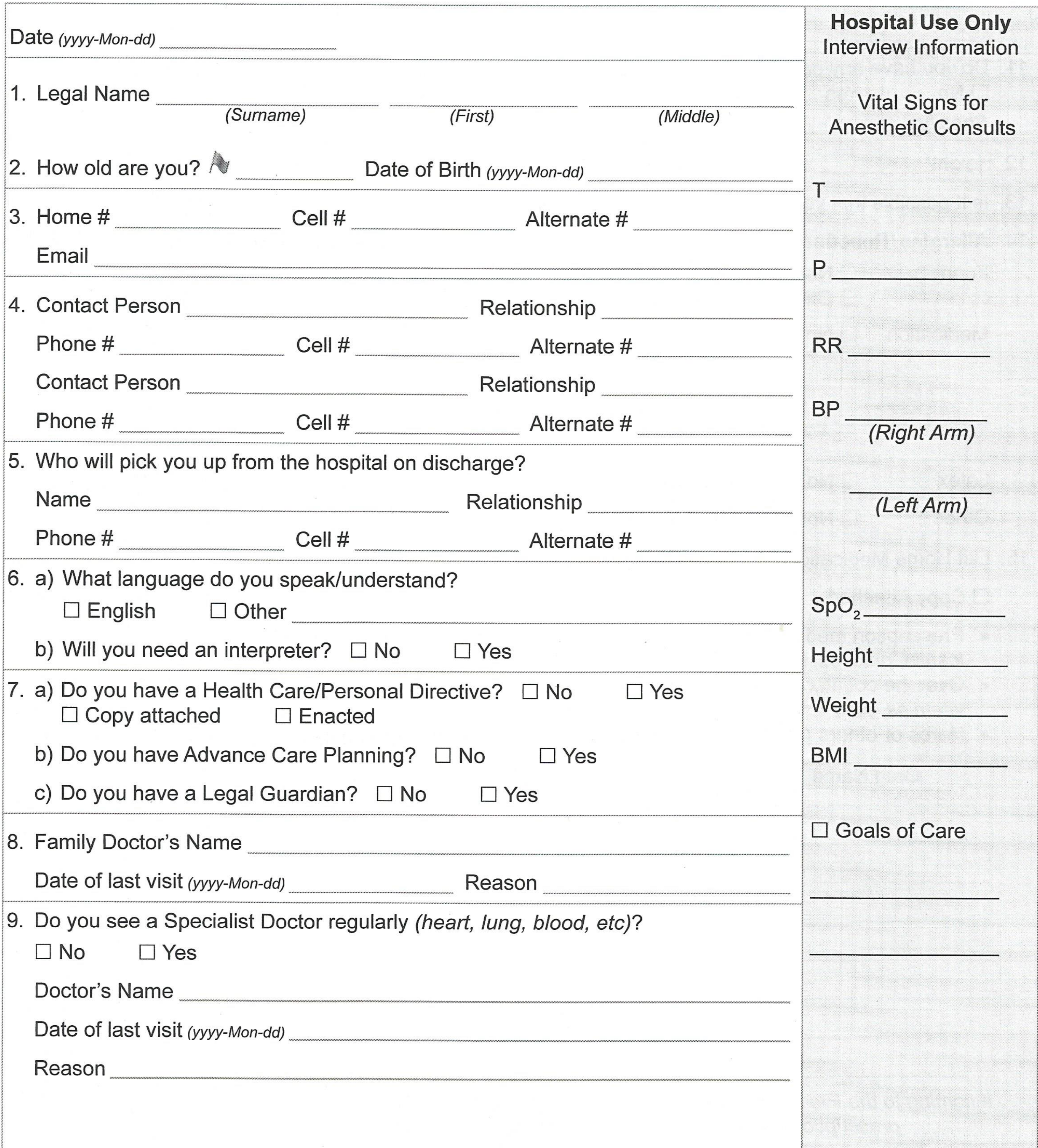
Alberta Health Services

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.

Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*
Gender
PHN#

Patient Assessment

Patients – Please fill out this form so your Health Care Team can better meet your needs.



Date *(yyyy-Mon-dd)* ____________

1. Legal Name ____________ (Surname) ____________ (First) ____________ (Middle)
2. How old are you? ________ Date of Birth *(yyyy-Mon-dd)* ____________
3. Home # ________ Cell # ________ Alternate # ________

   Email ____________

4. Contact Person ____________ Relationship ________

   Phone # ________ Cell # ________ Alternate # ________

   Contact Person ____________ Relationship ________

   Phone # ________ Cell # ________ Alternate # ________

5. Who will pick you up from the hospital on discharge?

   Name ____________ Relationship ________

   Phone # ________ Cell # ________ Alternate # ________

6. a) What language do you speak/understand?

   ☐ English ☐ Other ____________

   b) Will you need an interpreter? ☐ No ☐ Yes

7. a) Do you have a Health Care/Personal Directive? ☐ No ☐ Yes

   ☐ Copy attached ☐ Enacted

   b) Do you have Advance Care Planning? ☐ No ☐ Yes

   c) Do you have a Legal Guardian? ☐ No ☐ Yes

8. Family Doctor's Name ____________

   Date of last visit *(yyyy-Mon-dd)* ________ Reason ________

9. Do you see a Specialist Doctor regularly *(heart, lung, blood, etc)*?

   ☐ No ☐ Yes

   Doctor's Name ____________

   Date of last visit *(yyyy-Mon-dd)* ____________

   Reason ____________

Hospital Use Only
Interview Information

Vital Signs for Anesthetic Consults

T ________

P ________

RR ________

BP ________ *(Right Arm)*

________ *(Left Arm)*

SpO_2 ________

Height ________

Weight ________

BMI ________

☐ Goals of Care

____

____

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Patient Assessment

10. Reason for admission/surgery ______________________________

11. Do you have any pain? ☐ No ☐ Yes — 0 1 2 3 4 5 6 7 8 9 10 *(no pain)* … *(worst possible)*
    Specify ______________________________

12. Height ________ ☐ inches ☐ cm Weight ________ ☐ lbs ☐ kgs

13. Is it possible that you could be pregnant? ☐ No ☐ Yes

14. **Allergies/Reactions** — **Indicate Reaction**
    - Food ☐ No ☐ Yes ☐ Lactose ☐ Gluten ☐ Other Foods *(Specify)*
    - Medication ☐ No ☐ Yes *(Specify)*
    - Latex ☐ No ☐ Yes *(Specify)*
    - Other ☐ No ☐ Yes *(Specify)*

15. List Home Medications or attach a copy of your medications list.

    ☐ Copy Attached

    - Prescription medications *(i.e. birth control pills, creams, eye drops, inhalers, insulin, patches, sleeping pills, etc.)*
    - Over the counter medications *(e.g. aspirins, cold/allergy drugs, laxatives, vitamins, etc.)*
    - Herbs or others *(i.e. garlic, ginkgo biloba, St. John's Wort, Glucosamine, etc.)*

Drug Name	Dose (grams or mg)	How Often	Reason

If coming to the Pre Admission Clinic / Hospital please bring all containers of prescriptions and over the counter medications with you.

Hospital Use Only
Interview Information

☐ Urine hCG

☐ Latex Form Completed

☐ Medication Reconciliation Completed

Alberta Health Services

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Patient Assessment

16. Do you have Obstructive Sleep Apnea (OSA)? ☐ No ☐ Yes

17. Do you use CPAP? ☐ No ☐ Yes

18. a) Do you snore loudly (loud enough to be heard through closed doors)? ☐ No ☐ Yes
    b) Do you think you have abnormal or excessive sleepiness during the day? ☐ No ☐ Yes
    c) Has anyone noticed that you momentarily stop breathing during your sleep? ☐ No ☐ Yes
    d) Do you have or are you being treated for high blood pressure? ☐ No ☐ Yes

19. Do you smoke? ☐ No ☐ Yes
    How many per day? ______ Number of years smoked? ______
    When did you quit? ______

20. Do you drink beer/wine/liquor? ☐ No ☐ Yes
    Number of drinks per week? ______

21. Do you use recreational drugs? ☐ No ☐ Yes
    Type ______ How Often? ______

22. Do you have:
    - ☐ Capped or loose Teeth
    - ☐ Dentures ☐ Upper ☐ Lower
    - ☐ Eyeglasses
    - ☐ Contact Lenses
    - ☐ Hearing Aid ☐ Right ☐ Left
    - ☐ Body Piercing *(Specify)* ______
    - ☐ Intraocular Lens Implant ☐ Right ☐ Left
    - ☐ Prosthesis/Implants ______
    - ☐ None

23. Do any of these things make you feel short of breath or give you tightness in your chest or are you unable to complete them for any reason?
    a) Lying flat in bed ☐ No ☐ Yes
    b) Climbing 1 flight of stairs ☐ No ☐ Yes
    c) Walking 1 block ☐ No ☐ Yes
    d) Housework, getting dressed ☐ No ☐ Yes

Hospital Use Only
Interview Information

☐ Known Obstructive Sleep Apnea

OSA Risk Indicators:

- ☐ Snores Loudly
- ☐ Tired *(excessive sleepiness during day)*
- ☐ Observed *(stopped breathing during sleep)*
- ☐ Pressure *(has or being treated for high blood pressure)*
- ☐ BMI *(greater than 35 kg/m²)*
- ☐ Age *(over 50)*
- ☐ Neck circumference *(greater than 40 cm)*
- ☐ Gender *(male)*

OSA Risk Indicators: ______ / 8

- ☐ High Clinical Suspicion if 3 or more risk indicators
- ☐ Anesthetic consult completed if High Clinical Suspicion and Major Surgery
- ☐ Note on Kardex
- ☐ OSA Information Sheet

Pre-Admission Use Only:

Exercise Tolerance in metabolic equivalents (METS) as reported by patient

- ☐ ET 4 METs or higher *(Patient has checked 'no' to all boxes)*
- ☐ ET *less than* 4 METs *(Patient has checked yes to any box)*

Alberta Health Services

Patient Assessment

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24. List any Operations you have had:

Operation	Date *(yyyy-Mon-dd)*

The last time that you had surgery, did you experience confusion, hallucination or behavior that was unusual for you? .... ☐ No ☐ Yes

Have you ever had anesthetic? .... ☐ No ☐ Yes

Have you ever had a problem with the anesthetic?

Explain ____________________

Has anyone in your family ever had a problem with an anesthetic?.. ☐ No ☐ Yes

Explain ____________________

25. Transfusion History:

Have you ever received blood or blood products?.................. ☐ No ☐ Yes

a) Did you have any problems? .... ☐ No ☐ Yes

b) Do you have a rare blood type or been told that you have antibodies?.. ☐ No ☐ Yes

c) Do you have an antibody card? .... ☐ No ☐ Yes

d) Do you object to blood or blood product transfusion for any reason?.. ☐ No ☐ Yes

Hospital Use Only
Interview Information

For patients older than 65 years of age, flag at risk for delirium if:

- ☐ older than 80 years of age
- ☐ benzodiazepines and/or alcohol more than 3 x/week
- ☐ glasses and/or hearing aides
- ☐ Previous Delirium
- ☐ assistance with any activities or daily living

Delirium Risk Flags: ________ /5

Delirium Risk if greater than 2 flags. Implement facility protocol.

- ☐ Information pamphlet given
- ☐ Delirium watch noted on PAC Checklist
- ☐ Confusion Assessment Method Score (CAM) on chart
- ☐ Note on Kardex
- ☐ N/A – less than 65 years of age

☐ Known antibodies – notify Blood Bank by calling 403.343.4827

Alberta Health Services

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Patient Assessment

26. Nutrition Status ☐ No Concerns
If answered No Concerns proceed to question 27
a) Special type of diet ______
Describe eating pattern ______
b) Difficulty eating or swallowing? ☐ No ☐ Yes
c) Weight pattern? ☐ Stable ☐ Gain ☐ Loss Amount ______
Time period ______
☐ Nausea ☐ Vomiting ☐ Choking ☐ Indigestion ☐ Reflux ☐ Anorexia

27. Elimination Status ☐ No Concerns
If answered No concerns proceed to question 28
a) Urinary pattern? ☐ Urgency ☐ Incontinent ☐ Frequency
☐ Get up During the night
Describe urinary pattern ______
b) Bowel pattern? ☐ Diarrhea ☐ Constipation ☐ Incontinent ☐ Ostomy
Describe bowel pattern ______
c) Other? ☐ No ☐ Yes
Describe ______

28. Functional Status ☐ No Concerns
If answered No concerns proceed to question 29.
a) Any changes in activities of daily living? ☐ No ☐ Yes
Explain ______
b) Do you require assistance with toileting, bathing, dressing, walking, feeding? ☐ No ☐ Yes
Explain ______
c) Do you use any of these? ☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair ☐ Scooter ☐ Mechanical Lifts ☐ Bathroom Assists
Explain ______
d) Any changes in Sleep pattern? ☐ No ☐ Yes
Explain ______

29. Are you using any community services right now? .... ☐ No ☐ Yes
If answered No proceed to question 30
☐ Home Care ☐ Physiotherapy ☐ No Services
☐ Dietitian ☐ Occupational Therapy ☐ Lifeline
☐ Handi-transit ☐ Other
☐ Treaty Number ______ ☐ Band Name ______
☐ Social Assistance Case Worker Name ______
Phone # ______ Case # ______

30. What are your living arrangements?
a) Lives ☐ Alone ☐ Spouse/partner ☐ Child(ren) ☐ Pets
☐ Other *(specify)* ______
b) Residence ☐ Apartment ☐ House ☐ Group Home
☐ Supportive Housing ☐ Assisted Living ☐ Other
Explain ______
c) Must use stairs? ☐ No ☐ Yes Number ______
Is there a railing? ☐ No ☐ Yes

Hospital Use Only
Interview Information

☐ Discharge Planning Required
Reason: ______

☐ Home Care Notified

☐ Hospital Environmental Information Given
☐ Personal Care Items
☐ Valuables
☐ TV/telephone/radio
☐ Electrical appliances
☐ Smoking
☐ Visiting Policy
☐ Pastoral Care
☐ Unit Orientation
☐ Nurse call system
☐ Meal and snack times
☐ CCTV
☐ Name Placard on door

* Tell patient their name will be placed on a placard outside the room. If patient objects to this, the placard must be removed.
* Note same on Kardex

Alberta Health Services

Patient Assessment

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Gender
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31. Health History: Place a mark (X) if you have any of these ☐ **None**

☐ Chest Pain
☐ Angina
☐ Heart Attack
☐ Congestive Heart Failure
☐ Heart Murmur
☐ Heart beats fast, Skipped beats
☐ Rheumatic Fever
☐ High Blood Pressure
☐ Persistent swelling in legs and/or feet
☐ Stroke
☐ Transient Ischemic Attack (TIA)/Mini-Stroke
☐ Blood Clots *(legs, lungs, pelvis)*
☐ Bleeding Problems
☐ Anemia/Low iron
☐ Blood Transfusion
Date ____________ *(yyyy-Mon-dd)*
☐ Implanted Electronic Devices *(i.e. pacemaker, Internal defibrillator)*
☐ C. Difficile
☐ MRSA
☐ VRE

☐ Lung Problems
☐ Shortness of Breath, Cough, Wheeze
☐ Asthma
☐ Home Oxygen
☐ CPAP/BiPAP Machine
☐ Diabetic *(takes insulin)*
☐ Diabetic *(no insulin)*
Usual blood sugar Range ________
☐ Thyroid problems
☐ Glaucoma
☐ Blindness
☐ Frequent Heart Burn
☐ Ulcers
☐ Hepatitis/Jaundice/Liver Disease
☐ Bowel Disease
☐ Kidney/Bladder Problems
☐ Hemodialysis
☐ Peritoneal Dialysis
☐ Open Wounds
☐ Skin Rashes
☐ Migraines/Headaches
☐ Blackouts/Fainting spells in last year
☐ Seizures

☐ Recent Memory Loss
☐ Mental Health Issues
☐ Anxiety/Panic Attacks
☐ Depression
☐ Dementia
☐ Chronic Pain
☐ Disease of Nervous System *(i.e. MS)*
____
☐ Parkinson's Disease Tremors
☐ Muscle Disease
☐ Joint/Bone Problems *(i.e. Arthritis)*
____
☐ Falls within 6 months
☐ Gout
☐ HIV/AIDS
☐ Malignant Hyperthermia
☐ Pseudocholinesterase Deficiency
☐ Cancer
____
☐ Hearing Deficit

Other ____

____

____

32. Who completed this form?
☐ Patient
☐ Other Name/Relationship ____________________________

Signature ____________________ Date *(yyyy-Mon-dd)* ____________

Reviewed by ____________________ Date *(yyyy-Mon-dd)* ____________
(Nurse Signature)