El Camino Hospital® Los Gatos

815 Pollard Road, Los Gatos, CA 95032

Patient Label

PATIENT ADMISSION HISTORY QUESTIONNAIRE

Patients Name: _____ Date of Admission: _____Physician:_____

□Ambulatory □Wheelchair □ other walking devices_____

Have you been admitted to a hospital within 30 days? □ No □ Yes (explain) _____

Is your Primary Language English? □ Yes □ No (Language) _____

Interpreter needed? □ No □ Yes (relationship of translator) _____

Are you Pregnant or Lactating? □ No □ Yes

LATEX Allergy: □ No □ Yes (reaction) _____

TAPE Allergy: □ No □ Yes (reaction) _____type of Tape _____

Please **list ALL ALLERGIES** (include any food/medication/contact allergies) with all the reactions:

_____

_____

Any History of Transfusion reactions? □ No □ Yes _____

Any History of Anesthesia reactions? □ No □ Yes _____

Anything we should be aware of such as implantable devices, pacemakers, dialysis shunts, IV ports?

□ No □ Yes (explain) _____

If you have a CPAP or BIPAP machine, please bring in the day of surgery

MEDICATION LIST (include **ALL** medications including over the counter and vitamins)

If you do not know the dosages, please bring in on the day of procedure

Medication	Dosage	Frequency	Reason

Did you stop any **Medications/Blood Thinners** prior to this procedure? □ No □ Yes (date) _____

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Hearing: □ Normal □ Hard of Hearing □ Deaf
Do you have hearing aids? □ No □ Yes □ Left Ear □ Right Ear □ Both Ears

Vision: □ Normal □ Cataracts □ Glaucoma □ Blind □ Normal with Glasses □ Contacts

Do you have any…? □ Dentures □ Upper □ Lower □ Partials □ Full □ Caps/loose teeth
Do you have any history of confusion with prior hospitalizations? □ No □ Yes (explain) _____

Current Signs and Symptoms (what are you here for) _____

Surgical History (please include **ALL surgeries**, including year)

_____

_____

_____

Medical History (ie: high blood pressure, diabetes, depression, cancer, heart and lung issues, disorders)

_____

_____

_____

Any history of Isolation or Infectious Diseases, □ No □ Yes (type) _____Onset Date: _____

Do you have an **Advance Directive**: □ No
□ **Yes,** I have an advance Directive elsewhere, I will to bring on day of admission
□ **Yes,** I already have brought a copy into El Camino Hospital
□ **NO,** but I would you like information regarding advance directive?

DVT Risk Factors (Deep Vein Thrombosis)
□ History of DVT or Pulmonary Edema
□ Irritable/Inflammatory bowel disease
□ Varicose Veins/ swollen legs
□ Family hx blood clots/clotting disorder
□ Birth control or Hormone replacement

History of Falling: □ **No** History □ **Yes,** Have you fallen within the last year? (explain)_____

Do you have any abnormal elimination (bladder, bowel, ostomy?) □ No □ Yes (explain) _____

Risk for Suicide (check all that apply):
□ Intoxication with alcohol or drugs
□ Are you presently suicidal or considering harming self
□ Chronic pain, illness or other debilitating illness/terminal illness
□ Current admission precipitated by overdose/suicide attempt
□ Have you had any recent self-harm or suicidal thoughts or attempts
□ Primary dx/chief complaint Emotional or Behavioral disorder
□ Admission precipitated by suicide attempt
□ None of the above

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Height: _____

Recent weight loss □ No □ Yes Poor eating d/t decreased appetite □ No □ Yes
Are you on PPN/TPN/ or tube feedings or plan to be on this admission? □ No □ Yes

If going home the same day, do you have someone to stay with you overnight? □ Yes □ No

Whom do you live with: □ Alone □ Spouse/Significant other □ Family □ Roommate
□ Board and care □ Independent living □ Assisted living □ SNF

Do you feel safe in your home? □ Yes □ No (explain) _____
Do you feel safe in your relationships? □ Yes □ No (explain) _____

Prior to hospitalization where you □ Independent □ Dependent on others (explain) _____
Religious/Cultural beliefs that would affect your hospital stay? □ No □ Yes (explain) _____
□ No blood products (Jehovah's Witness)

Do you have any wounds, skin disorders or breakdown anywhere on your body? □ No
□ Yes (describe and the location)_____

Current smoking status? □ Currently □ Everyday □ Some days □ Former □ Never

Caffeine intake (cups per day): □ 0 □ 1 □ 2-4
Description of alcohol use: □ Never □ Monthly □ Weekly □ Daily
□ 0-1 drinks □ 2-3 drinks □ 4 or more drinks
Do you take any street drugs or non-prescribed drugs? □ No □ Yes (describe) _____

Recent Influenza Vaccine: □ No □ Yes, this season
Would you like to receive the flu vaccine (if available)? □ No □ Yes

Pneumococcal Vaccination: □ No □ Yes
Would you like to receive the pneumococcal Vaccine? □ No □ Yes

Highest Educational Level: □ Elementary □ High School □ College □ Grad School □ Post Grad

Signature _____ Date _____ Time _____

Thank you for completing this questionnaire

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