BAYLOR Medical Center at Trophy Club

Please check any problems you may have now or ever had in the past

☐ **High Blood Pressure***
☐ **Chest Pain / Angina***
☐ **Heart Disease / Heart Attack /CABG**
☐ MVP/Heart Murmur
☐ **Irregular Heartbeat**
☐ High cholesterol
☐ **Rheumatic Fever**
☐ **COPD/CHF***
☐ **HOME O2**
☐ Asthma ☐ Seasonal Allergies
☐ Tuberculosis
☐ Emphysema
☐ Bronchitis
☐ Recent Flu or cold
☐ Chronic Cough
☐ Thyroid Problems
☐ Bleed/Blood disorders
☐ Anemia
☐ Hemophilia
☐ Blood Transfusion
☐ Hx. of blood clots ☐ Varicose veins
☐ Sleep Apnea ☐ w/ CPAP

Do you snore loudly(louder than talking or loud enough to be heard through closed doors? Yes No

Has anyone observed you stop breathing during your sleep?
Yes No

☐ Anticoagulants/blood thinners
☐ Bleed / Bruise easily
☐ **Dementia****
☐ **Degenerative Brain Disorders****
☐ Migraine Headaches
☐ Psychiatric disorder
☐ Confusion / memory loss
☐ Abuse / Neglect issues
☐ Depression
☐ Anxiety
☐ Suicide Ideation
☐ Fainting ☐ Blackouts
☐ Seizures_____
☐ Multiple Sclerosis
☐ Stroke ☐ Paralysis
☐ Recent fall / mobility issues
☐ Crutches ☐ Walker ☐ Cane
☐ Glasses/Contacts
☐ **Kidney Problems***
☐ Dialysis
☐ **Diabetes* IDDM / NIDDM**

Do you often feel tired, fatigued, or sleepy during daytime?
Yes No

Is your neck circumference greater than 15.75 inches?
Yes No

☐ Closed head injury or L.O.C.
☐ Nerve Injury
☐ Back / Neck injury / Pain
☐ Herniated Disc
☐ Steroid Use / Injections
☐ Fibromyalgia
☐ Lupus
☐ Arthritis
☐ HIV / AIDS
☐ **Liver Problems***
☐ Hepatitis A, B, C
☐ Pancreatitis
☐ Hiatal Hernia / ulcer
☐ Acid Reflux / GERD
☐ Constipation ☐ Crohn's
☐ Recent Nausea, vomiting, diarrhea
☐ Weight Loss/Gain. 10lbs.
☐ History: ☐ MRSA ☐VRE
☐ Recent Infection
☐ Immunization current
Pneumonia _____ Date
Influenza _____ Date
☐ Current Skin Rash / Sore

☐ **History of organ transplant(s)****
☐ Cancer
☐ **Chemotherapy***
☐ Radiation Therapy
☐ Difficulty opening mouth
☐ Loose / chipped teeth
☐ Dentures / False teeth ↑↓
☐ Recent "toothache", abscess or dental problems
☐ Body piercing
☐ Hoarseness
☐ Hard of Hearing
☐ Hearing aid(s)
☐ Recreational drug use
Type_____ amt_____
☐ Tobacco use
_____ ppd_____ yr(s)
☐ E-Cigs ☐ Oral Tobacco
Discussed Tobacco Cessation
☐ Alcohol use amt_____
☐ History of Nausea with Anesthesia
☐ History of motion sickness
Last Menstrual Period _____

*** Refer to Anesthesia Guidelines for further testing**
**** Complete TSE Screening Tool**

Previous Non-surgical Hospitalizations? _____
Any Other medical problems/conditions not listed above:
_____

Significant Family Medical History: _____

☐ **Primary Language** _____ ☐ **Language-Line Needed for interpretation**

Surgical History

Surgery	Date	Surgery	Date

Any problems with previous surgery? **Yes/No** _____
Family or personal history of problems with anesthesia such as Malignant Hyperthermia demonstrated by high fever or cardiac arrest? **Yes/No**_____

Bariatric (Weight loss) Surgeries and/or Revisions

Surgery	Physician / Facility	Date

Pre-Admit Testing Vitals

Ht: _____ Wt: _____
BMI: _____
Pain: _____
Temp: _____
BP: _____
HR: _____ SpO2% ____
RR: _____

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BAYLOR
Medical Center
at Trophy Club

Emergency Contact/ Relationship to patient

_____

Phone # _____ Cell #_____

Work #_____

Primary Care Physician

Name: _____ Phone #:

_____

Cardiologist :

Name: _____ Phone #:

_____

Specialist Information:

Name: _____ Phone #:

_____

Primary Pharmacy:

Name: _____ Phone #:

_____

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