El Camino Hospital
THE HOSPITAL OF SILICON VALLEY
2500 Grant Road, Mountain View, CA 94040 4378

Patient Label

Patient Admission Information

Name: _____ Birth Date: _____

Surgery Date: _____ Surgery Time: _____

Type of Surgery: _____ Length of Stay: _____

Please answer the following questions:

	(Check One) YES	NO
Have you been admitted to a hospital in the last 30 days?	☐	☐
Are you a dialysis patient?	☐	☐
Is your primary language English?	☐	☐
If 'NO', what language do you speak? _____		
Please check if you are you left-handed ☐ or right-handed ☐?		
Females only: Are you pregnant or breastfeeding?	☐	☐
Do you have allergies? If yes list which medications/reaction?	☐	☐
_____		
_____		
_____		
Contact allergies/reaction (Latex? Adhesives?) _____	☐	☐
Environmental Allergies/Reaction? (Seasonal, dust, pollens, etc.?)	☐	☐
_____		
Have you ever had a reaction to a blood transfusion?		
Have you ever had a reaction to anesthesia?	☐	☐
Any history of confusion during a hospitalization?	☐	☐
Do you wear glasses?	☐	☐
Do you wear contacts?	☐	☐
Do you wear dentures? ☐ lower ☐ full or ☐ partial	☐	☐
☐ upper ☐ full or ☐ partial	☐	☐
Do you wear a hearing aid(s)? ☐ Right ☐ Left	☐	☐
Have you ever signed an Advanced Directive? If yes	☐	☐
please bring a copy with you to the hospital if not on file.		
Is a copy on file?	☐	☐

Please list any previous surgeries you have had:

Type	Date

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Please check if you are currently being treated for any of the following medical conditions.

- ☐ Heart problems
- ☐ Blood Clots
- ☐ Diabetes
- ☐ Arthritis
- ☐ Acid Reflux / Ulcer
- ☐ High Blood Pressure
- ☐ Other: _____
- ☐ Lung problems
- ☐ COPD/ Emphysema
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ MRSA Infection
- ☐ Cancer

	(Check One) YES	NO
Any family history of blood clots or clotting disorders?	☐	☐
Any history of falls in the last 12 months?	☐	☐
Do you use any assistance to walk? If 'YES', what device? _____	☐	☐
Do you have any dietary restrictions? If 'YES', what type? _____	☐	☐
Any recent weight loss or trouble with nausea/vomiting?	☐	☐
Are you in any pain right now? If 'YES', what level (0/10) _____	☐	☐
Where? _____	☐	☐
Please list your emergency contact: _____		
Relationship: _____ Phone Number: _____		
Do you live alone?	☐	☐
Do you live with family?	☐	☐
Do you live with others?	☐	☐
Do you feel safe in your home?	☐	☐
Do you feel safe in your relationships?		
Do you rely on others for help with daily care? If yes, please explain _____	☐	☐
Do you have any cultural/religious beliefs that would affect your hospital care? (i.e. Jehovah's Witness: No Blood Products, etc.) _____	☐	☐
Any skin problems, open wounds, rash, or skin disorders? _____	☐	☐
Are you a smoker? If 'YES', how much? If quit, when? _____	☐	☐
Any use of caffeine? If 'YES', how many cups/day? _____	☐	☐
Any use of alcohol? If 'YES', how much? _____ Type? _____	☐	☐
Any use of street drugs / recreational drugs? If 'YES' Type? _____	☐	☐

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Have you had the influenza vaccine this season? (October through March) If 'YES', when?

_____

Have you ever had the pneumonia vaccine? If 'YES', when? _____

HEIGHT _____ **ft** _____ **in.** **WEIGHT** _____

What is your highest Educational level ☐ Elementary ☐ High School ☐ College ☐ Graduate school ☐ Post graduate

Please list the medications you are currently taking, include over the counter herbals, vitamins, or suppliments.

Name	Dose	How often	Last time taken	Reason

_____ **See attached list**

Have you stopped any medications prior to surgery? (i.e. Aspirin, Coumadin. Plavix, and/or blood thinners?)

	YES	NO
If YES, which medications/date and time stopped	☐	☐

_____

_____

Thank you for completing this form.

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