UCHealth
University of Colorado Hospital

PRE-PROCEDURE and ADMISSION SCREENINGS

Patient Information

Home phone _____ Work _____ Local/cell number _____
Would it be best to call you at ❑ home ❑ work Can we leave a message? ❑ Yes ❑ No

Home address _____ City _____ State _____
E-mail _____
Primary care physician _____ Phone _____ Fax_____
Emergency contact _____ Relation _____ Phone _____

Admission Screenings

ALLERGIES	Reaction		Reaction	Other Allergies	Reaction
❑ No known		❑ Contrast dye	_____	❑ Banana	_____
❑ Penicillin	_____	❑ Fish/shellfish	_____	❑ Kiwi	_____
❑ Sulfa	_____	❑ Avocado	_____	_____	_____
❑ Latex	_____	❑ Chestnuts	_____	_____	_____

Communication
Check all that apply
❑ Speak English ❑ Understand English
❑ Read English ❑ Speak Spanish
Other language _____
_____

Have you ever been told you have an infection that is resistant to antibiotics? ❑ No❑ Yes
If yes, ❑ MRSA ❑ VRE ❑ other ❑ Don't know
If patient answers yes, send notification to UCH Infection Control Team

Psycho/Social
Do you smoke? ❑ No ❑ Yes **Ever smoked?** ❑ No ❑ Yes
If so, _____ packs / per day / for _____ yrs
Quit in the last 12 months ❑ No ❑ Yes
Do you drink alcohol? ❑ No ❑ Yes
how much_____how long_____
Are you currently using recreational drugs?
❑ No ❑ Yes
Do you have any body piercing? ❑ No ❑ Yes If so, where _____

PREPROCEDURE SCREENING

Have you or anyone in your family had problems with general anesthesia?
❑ no ❑ yes
If yes, describe
❑ You ❑ Family member _____
_____
_____

Do you have or have you had?
❑ problems bending your neck
❑ problems opening your mouth
❑ head injury ❑ seizure disorder
❑ stroke / TIA ("mini stroke")
❑ liver disease ❑ hepatitis ❑ HIV
❑ diabetes
❑ kidney disease
❑ thyroid disease
❑ rheumatoid arthritis
❑ osteoarthritis
❑ GERD/reflux/heartburn
❑ cancer –what kind _____

❑ trouble breathing lying flat
❑ asthma
❑ shortness of breath
❑ shortness of breath on exertion
❑ lung disease ❑ emphysema
❑ use oxygen
❑ sleep apnea ❑ use CPAP
❑ told I snore
❑ frequently tired during the day
❑ told I stop breathing when asleep
❑ high blood pressure
❑ take blood pressure medication
❑ irregular heart beats
❑ heart attack
❑ heart surgery
❑ blood clots
❑ abnormal EKG
❑ high cholesterol
❑ chest pain /pressure/angina
Explain- _____
❑ heart murmur

❑ abnormal heart stress test
When_____ Where_____
❑ abnormal heart ultrasound
When_____ Where_____
❑ abnormal heart ultrasound
When_____ Where_____
❑ pacemaker/internal defibrillator
→Type/model of pacemaker_____
Are you
❑ Under the care of a heart doctor
Name _____
Phone #_____

❑ **No items apply**

List past surgeries/medical issues
_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____

Important note-
Please see back side to list your medications → → →
Height _____ **Weight** _____

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Current Home Medications

(Include prescriptions, herbals, over-the-counter drugs, inhalers, patches, pumps, etc.)
IF you have a list of your medications please provide this to your provider and they will make a copy or be sure it is entered into the computer system.

Medication Name	**Dose** (Strength or concentration)	**Route** (By Mouth, Injection, etc.)	**Frequency** How many times a day do you take this?	**Indication** Why are you taking this?	

PATIENT SIGNATURE _____ Date _____

The above information has been reviewed and verified with the patient.
Clinic RN SIGNATURE _____ Date _____