

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE SAME DAY AMBULATORY SURGERY PRE-ADMISSION ASSESSMENT	OTSG APPROVED (Date)
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1. Proposed surgery		2. Scheduled date		3. Service		4. Surgeon	
5. Vital signs: BP	T	P	R	O2	Pain level	5a. Pain location	6. Age
						7. Height	8. Weight
9. Orientation <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Other: _____ LMP: _____							
10. Nursing considerations (Select all that apply. Write in any that are not listed.)							
a. Cardiovascular: <input type="checkbox"/> MI <input type="checkbox"/> Hypertension <input type="checkbox"/> Angina <input type="checkbox"/> Stroke <input type="checkbox"/> pacemaker <input type="checkbox"/> Other:							
b. Respiratory: <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> TB <input type="checkbox"/> Other:							
c. Blood disorders: <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding tendencies <input type="checkbox"/> Transfusions <input type="checkbox"/> Other:							
d. Hypatic system: <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Other:							
e. Neuro/Musculoskeletal: <input type="checkbox"/> Migraines <input type="checkbox"/> Seizures <input type="checkbox"/> Arthritis <input type="checkbox"/> Other:							
f. Endocrine: <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid <input type="checkbox"/> Other:							
g. GI/GU: <input type="checkbox"/> Kidney stones <input type="checkbox"/> UTI <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Ulcers <input type="checkbox"/> STD <input type="checkbox"/> Other:							
h. Skin integrity: <input type="checkbox"/> Intact <input type="checkbox"/> Ulcerated <input type="checkbox"/> Abraded <input type="checkbox"/> Other:							
11. Allergies and reactions:							
a. Medication		b. Dye		c. Other			
12. List all medications you take at home, the dosage and how often (Include all over-the-counter and herbal medications.)							
13. In the past two weeks, have you been exposed to any of the following? <input type="checkbox"/> Colds <input type="checkbox"/> Flu <input type="checkbox"/> Viruses <input type="checkbox"/> Communicable diseases							
14. Substance abuse history							
a. Smoking: <input type="checkbox"/> Yes <input type="checkbox"/> No		b. _____ Packs per day x _____ years		c. Drug/alcohol amount:			
15. Mobility limitations <input type="checkbox"/> None <input type="checkbox"/> Arthritis <input type="checkbox"/> Prosthesis <input type="checkbox"/> Other Comments: _____							
16. Sensory deficits <input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Hearing aid <input type="checkbox"/> Dentures <input type="checkbox"/> Deafness <input type="checkbox"/> Blindess <input type="checkbox"/> Other Comments: _____							
17. Language Primary language: _____ Reads& writes? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: _____							
18. List all previous surgeries							
19. Adverse reactions to anesthesia							
a. Have you ever had an adverse reaction to anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what kind of RX?							
b. Has any family member had a problem with anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: _____							
20. Psychological concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: _____				21. Cultural/Religious concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: _____			
22. Adv dir? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		23. Home ph: _____		24. Work ph: _____		25. Occupation: _____	
26a. Reviewed by (Print name and title)			b. Signature			c. Date	

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

- HISTORY/PHYSICAL FLOW CHART
- OTHER EXAMINATION OR EVALUATION OTHER (Specify)
- DIAGNOSTIC STUDIES
- TREATMENT

