Scripps

☐ Scripps Mercy Hospital Chula Vista ☐ Scripps Memorial Hospital La Jolla
☐ Scripps Memorial Hospital Encinitas ☐ Scripps Mercy Hospital
☐ Scripps Green Hospital

PRE-ANESTHESIA HEALTH HISTORY

Please Complete This Page

ADDRESSOGRAPH

NAME	HEIGHT	WEIGHT	OCCUPATION	AGE

YES NO

☐ ☐ Are you **ALLERGIC** to anything? Name medications and type of reactions (include latex rubber products, sulfites and food preservatives). _____

_____

☐ ☐ Are you taking any **MEDICATIONS?** (Include prescription, over the counter, eye drops, inhalers and herbal medications).

MEDICATION	DOSE	HOW OFTEN?	LAST TAKEN?
Please list all medicines you are taking at home on the Green Sheet. (Include prescriptions, over-the counter, samples, supplements and herbals).			

NOTE: IF YOU HAVE BEEN TAKING ANY ILLICIT (STREET) DRUGS, PLEASE TELL THE ANESTHESIOLOGIST. THIS IS IMPORTANT FOR YOUR SAFETY.

☐ ☐ Have you had previous **SURGERIES?** What anesthetics (local, block, spinal, epidural, general, awake or asleep)?

SURGERY	YEAR	ANESTHESIA

☐ ☐ Can you climb a flight of stairs? 0 ____ 1 ____ 2 ____ 3 or more ____

☐ ☐ Have you ever had problems with anesthetics (nausea, vomiting; malignant hyperthermia)? _____

☐ ☐ Has anyone in your family had unusual reactions to anesthetics? _____

☐ ☐ Have you / your friends / family (circle one) donated blood for your surgery? How many units? _____

YES NO **PLEASE CIRCLE THOSE THAT PERTAIN TO YOU:**

☐ ☐ Irregular Heart Beat / Heart Disease / Heart Valve Disease / Mitral Valve Prolapse _____
☐ ☐ Heart Attack / Angina / Chest Pain / Fainting _____
☐ ☐ High Blood Pressure _____
☐ ☐ Do you have a Cold / Cough / Asthma (Wheezing)? _____
☐ ☐ Lung Disease / Difficulty Breathing / Sleep Apnea _____
☐ ☐ Tobacco, How Much, How Long? Quit? _____
☐ ☐ Frequent Headaches / Stroke / Neurologic Disease _____
☐ ☐ Nervous Disorder / Seizures _____
☐ ☐ Diabetes / Thyroid Disease _____
☐ ☐ Kidney Disease / Liver Disease _____
☐ ☐ Infectious Disease (Hepatitis, HIV, TB, etc.) _____
☐ ☐ Heartburn, Gastritis, Esophageal Reflux, Hiatal Hernia, Ulcer _____
☐ ☐ Drink Alcoholic Beverages, How Much? _____

CONTINUED ON NEXT PAG

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YES	NO	**PLEASE CIRCLE THOSE THAT PERTAIN TO YOU:**
☐	☐	Drug Use _____
☐	☐	Arthritis / Rheumatism, Where? _____
☐	☐	Difficulty Opening Mouth or Moving Neck
☐	☐	Dentures, Chipped Loose Teeth, Special Dental Work
☐	☐	Bleeding / Blood Transfusion / Bruising / Sickle Cell / Clotting Problems _____
☐	☐	Contact Lenses / Glaucoma _____
☐	☐	If you are not here related to a pregnancy, are you possibly **pregnant?** _____
☐	☐	Are you currently breastfeeding?

IS THERE ANYTHING ELSE WE SHOULD KNOW? _____

Acknowledgement of Risks of Anesthesia

Modern anesthesia is safe and usually well tolerated. However, even in experienced and competent hands, complications can occur. Minor problems include nausea and vomiting, headache, and injury to vocal cords, teeth and dental work. Serious complications include nerve injury, damage to one or more of the vital organs, even major disability or death. Other complications can occur. Although major complications of anesthesia are fortunately rare in healthy people, some types of health problems increase the risk of such occurrences. Therefore, it is important that you fully and accurately complete the health history questionnaire: "Pre-Anesthesia Health History."

Prior to surgery, an anesthesiologist will talk with you. During this preoperative visit, you are encouraged to discuss to your satisfaction the recommended anesthesia, the possible alternatives, as well as a more detailed discussion of the risks of anesthesia mentioned above. Please ask as many questions as you feel necessary in order to assist you in making an informed decision.

Your signature on this page indicates your acknowledgement that risk of complication always exists as a result of anesthesia management.

If you have questions, please ask your anesthesiologist to answer them.

Date: _____ Time: _____ ☐ a.m. ☐ p.m.

Signature: _____
Patient/Legal Representative

DO NOT REMOVE FROM PATIENT CHART

Scripps Mercy Hospital

List of Home Medications (to be Reconciled)

☐ Takes no medicines at home (including supplements, OTCs, or herbal)

Medicine Name/Route	Dose	How Often	Medication Status (Physician/LIP ONLY)
			AT DISCHARGE: ☐ Continue ☐ Discontinue ☐ Other:
Last Dose Taken (pre-admission):	Purpose:		Next Dose Due (on discharge)
			AT DISCHARGE: ☐ Continue ☐ Discontinue ☐ Other:
Last Dose Taken (pre-admission):	Purpose:		Next Dose Due (on discharge)
			AT DISCHARGE: ☐ Continue ☐ Discontinue ☐ Other:
Last Dose Taken (pre-admission):	Purpose:		Next Dose Due (on discharge)
			AT DISCHARGE: ☐ Continue ☐ Discontinue ☐ Other:
Last Dose Taken (pre-admission):	Purpose:		Next Dose Due (on discharge)
			AT DISCHARGE: ☐ Continue ☐ Discontinue ☐ Other:
Last Dose Taken (pre-admission):	Purpose:		Next Dose Due (on discharge)
			AT DISCHARGE: ☐ Continue ☐ Discontinue ☐ Other:
Last Dose Taken (pre-admission):	Purpose:		Next Dose Due (on discharge)
			AT DISCHARGE: ☐ Continue ☐ Discontinue ☐ Other:
Last Dose Taken (pre-admission):	Purpose:		Next Dose Due (on discharge)
			AT DISCHARGE: ☐ Continue ☐ Discontinue ☐ Other:
Last Dose Taken (pre-admission):	Purpose:		Next Dose Due (on discharge)

I obtained and reviewed the home medication list from the patient/family upon admission: ☐ Unable to obtain medical history

Sources include: ☐ Patient list ☐ Pt/family recall ☐ Pharmacy ☐ MD list ☐ Previous H&P ☐ Other: ____________

AT ADMISSION:

Nurse signature/date:____________________ **Nurse** signature/date:____________________

SCANNED TO PHARMACY(all in-patients): ____________________ ____________________

Signature Date/time Signature Date/Time

I have reviewed and reconciled the home medication list:(For out-patient areas - Physician sign @ discharge ONLY)

ON ADMISSION: Physician/LIP signature: ____________________ Date/time: ____________

On Discharge: Physician/LIP signature: ____________________ Date/time: ____________

I provided a COPY of these instructions to the patient/family at discharge:

On Discharge: Nurse signature: ____________________ Date/time: ____________

SAN DIEGO
HANDSPECIALISTS
CARE OF THE HAND & UPPER EXTREMITY

STATEMENT OF COMPREHENSION

INSTRUCTIONS

Read this form completely. **INITIAL** each paragraph. If you agree with the statements, **WRITE "I UNDERSTAND"** on the line *above* your signature and **SIGN** where indicated at the bottom of the page. You MUST bring these papers to our office at the time of your Pre-Operative Visit.

Dear Patient:

☐ The reasons for undertaking this operation, anticipated goals, and possible complicating factors, and alternative methods of treatment have been discussed with you previously. We feel strongly that a patient wants to know what his or her medical problem is; expressed in terms you can understand. We have, therefore, tried to explain our proposed treatment in lay terms, so that you may understand the nature of your condition and the goals of the surgical treatment you have requested. If you have any questions about your procedure, please discuss them with us.

☐ Most orthopaedic procedures are done to arrest pain, to improve function, to prevent or correct an abnormal situation. Some times an exploratory type procedure is necessary when the exact diagnosis cannot be made with the usual clinical tools available to us. Some conditions can be treated non-operatively as well as operatively – often with the same results or similar results. The operative's choice of treatment, therefore, is based on medical knowledge and experience, and the patient's understanding of the problem. We have discussed these methods with you.

☐ All forms of treatment have certain risks associated with them. Some are far more risky than others. We have attempted to explain the risks and possible complications of your proposed operation with you. If you do not understand them or have some concern about some not mentioned, please ask us. Operations on nerves are particularly difficult for the patient and surgeon. Complaints of pain can be frequently relieved with surgical treatment. In some cases, however, pain does not subside and may become worse even though the operation is well performed and no specific injury or accident occurs during the procedure. This is because of the particular sensitive nature of nerves and the fact that internal nerve scarring may have occurred as a result of nerve compression. This internal scarring cannot be relieved with external decompression in all cases. The patient should understand that operations involving nerves carry a specific risk for persistent pain and/or weakness despite appropriate surgical intervention. If this is of concern to you, please discuss this with your surgeon.

☐ The responsibility for your surgical anesthetic will be undertaken by an anesthesiologist. You are encouraged to discuss the benefits, alternatives and possible complications with the anesthesiologist prior to your operation.

☐ _____ (← fill in Dr.'s name) has and ownership interest in _____ (← fill in facility name). You may choose another facility for your operation. If this is a concern, please discuss this with your surgeon.

☐ Some Orthopaedic & Hand Surgery operations require the use of metal plates, screws, pins & joint implants. All materials that remain in your body will experience wear and mechanical strain. These materials, regardless of high standards of manufacturing, may break loose, loosen, wear out, or become infected. In some cases your surgeon will advise removing a device when its job is done. This is a routine consideration when using implantable materials. If you have a concern about implant failure or need for removal, please discuss this with your surgeon.

_____

Patient Statement of Comprehension (please print "I UNDERSTAND" on the line above)

_____

Patient Name (please PRINT on the line above)

_____ ***Date:*** _____

Patient Signature (please SIGN on the line above)