

OUTPATIENT DATA BASE INFORMATION

Please complete the following

Information given by: _____ Relationship to patient: _____

Primary care physician: _____

What health problem brought you to the hospital? _____

Have you received treatment for the same condition within the last year? No Yes

Do you have any medical conditions related to the following? Age: _____ Weight: _____ Height: _____

- | | | | |
|----------------------------|--|----------------------------------|--|
| Heart | <input type="checkbox"/> No <input type="checkbox"/> Yes | Arthritis | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Lungs | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Surgery | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Bone/Joint Injuries | <input type="checkbox"/> No <input type="checkbox"/> Yes | High Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Seizure | <input type="checkbox"/> No <input type="checkbox"/> Yes | Pacemaker | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Urinary or Kidney Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes | Circulatory Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Dizziness or Fainting | <input type="checkbox"/> No <input type="checkbox"/> Yes | Neurological Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Balance Disorders | <input type="checkbox"/> No <input type="checkbox"/> Yes | Spinal Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Dialysis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sleep Disorder | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Transplant | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sleep Apnea | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| | | Stroke/Transient Ischemic Attack | <input type="checkbox"/> No <input type="checkbox"/> Yes |

If you answered yes to any of the above, please explain: _____

Do you have any other medical conditions that you think we should know about or for which you are receiving care? No Yes

If yes, please explain: _____

Please list any pertinent surgeries you have had including dates: _____

Do you use a cane or walker to help you walk? No Yes

List other equipment you use on a regular basis to help your function: _____

Have you been discharged from a hospital or received home health care within the last 30 days? If so, please list dates: _____

Have you had any falls? No Yes

If yes, when: _____ where: _____

At the present time would you say your health is: Excellent Very Good Fair Poor

Do you have pain? No Yes

If yes, where is your pain located? _____

Is your pain constant? No Yes Is your pain intermittent? No Yes

What makes your pain better? _____

Current pain (Circle one)	0 1 2 3 4 5 6 7 8 9 10
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Worst pain in the last 24 hours (Circle one)	0 1 2 3 4 5 6 7 8 9 10
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DALLAS, TEXAS



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Do you have any **IMPLANTS / PROSTHETICS**? No Yes
 If yes, please check those applicable:
 Lens Implants Pacemaker / Implantable Cardio Defibrillator Joint Replacement Pins / Rods Prosthetic Valves
 Implantable Pump / Devices _____ Medication Stent Location _____
 Tracheostomy Size _____ Other: _____

Have you smoked any type of tobacco (cigarettes, cigars, pipes) in the past twelve months? No Yes Within the last 30 days? No Yes
 Have you used any type of smokeless product (chewing tobacco, snuff, chewing unlit cigar, dip) in the past twelve months? No Yes
 Within the last 30 days? No Yes

Do you drink **LIQUOR / BEER / WINE**? No Yes If yes, how much? _____ How Often? _____

Do you have advanced directives for medical care? No Yes
 If yes, is a copy available to file in the chart? No Yes
 If a copy is unavailable please make a note of this in the chart.

Do you have any diet/liquid restrictions? No Yes
 If yes, please list: _____

Outpatient Learning Needs

Learning Needs: Are there any factors below, which would affect your ability to learn?

Hearing	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stress	<input type="checkbox"/> No <input type="checkbox"/> Yes
Reading	<input type="checkbox"/> No <input type="checkbox"/> Yes	Vision	<input type="checkbox"/> No <input type="checkbox"/> Yes
Writing	<input type="checkbox"/> No <input type="checkbox"/> Yes	Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
Memory Loss	<input type="checkbox"/> No <input type="checkbox"/> Yes	Language	<input type="checkbox"/> No <input type="checkbox"/> Yes
Comprehension	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cultural	<input type="checkbox"/> No <input type="checkbox"/> Yes
Religious	<input type="checkbox"/> No <input type="checkbox"/> Yes	Interpreter Needed	<input type="checkbox"/> No <input type="checkbox"/> Yes
Limited Attention Span	<input type="checkbox"/> No <input type="checkbox"/> Yes		

If you answered yes to any of the above, please explain: _____

Patient learns best by: *(please check all that apply)* Verbal Instructions Written Instructions Demonstration Practice

Name and relationship of those who wish to be involved in the learning / teaching process: _____

List all allergies / intolerances and reactions (food, drug, environmental, latex, iodine, shellfish, contrast medium.)

ALLERGY / INTOLERANCE	DESCRIBE REACTION

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