

Pre-Admit Testing Appointment Checklist



Please check-in for your Pre-Admit Testing appointment at the Concierge Desk, just inside the entrance to the Don and Linda Carter Outpatient Center.

This appointment will take approximately two hours. You do not need to be fasting for your Pre-Admit Testing appointment, and take any medications as usual on this day.

Please Bring With You:

- Your driver's license and insurance card
- A list of all your medications, with dosages, and when you take them. Please include herbals, vitamins and over-the-counter medications. Even if you don't take them regularly, please include them on the list.
- Any papers you were given at the surgeon's office
- Any EKG or heart tests you have had in the past 6 months. The EKG should be initialed by the physician.
- A report of any chest X-ray you have had in the past year (not the X-ray itself)
- Advance directives (i.e. living will or medical power of attorney) if you have any
- The following three pages of this folder filled out according to instructions

Steps Following Your Check-In

- Pre-register for your procedure
- Discuss fees and medical insurance for your procedure
- Pay deductibles, co-payments and a portion of your out-of-pocket expenses for your procedure
- Go to the Pre-Admit-Testing Department area (PAT)

During Pre-Admission Testing, You Will:

- Have blood work, EKG and chest X-ray, as needed
- Have height, weight and vital signs measurements
- Have a physical assessment by the nurse
- Sign your surgical consent
- Provide medical history information
- Receive detailed instructions concerning the day before your surgery, the day of your surgery and what to expect after your surgery

ANESTHESIA QUESTIONNAIRE

Date: _____ Day Phone: _____ Eve Phone: _____

1. See Universal Medication List
2. List all PREVIOUS SURGERIES, dates, and complications if any.

_____	_____
_____	_____
_____	_____
_____	_____

Name of you Primary Care Physician/ Fax # _____ Date of last check up _____ Date of last Chest X-ray/where _____ Date of last EKG/where _____

YES NO

3. Were there any complications with the anesthesia? Explain: _____
4. Were you told it was difficult to insert the breathing tube?
5. Have any of your blood relatives had problems with anesthesia? (e.g. high fevers, difficulty awakening)
6. Do you have allergies to any medications? List: _____
 Shellfish? Or Iodine? (Circle one if applicable) Reactions: _____
7. Do you have problems with your heart or blood vessels?
 previous heart attack? Date: _____
 chest pain/ angina?
 skipped heart beats or palpitations? Mitral valve prolapsed?
 heart failure, pacemaker or implanted cardiac defibrillator (ICD)?
 Have you had an increase in severity or frequency of your heart symptoms over the past year?
8. Have you been hospitalized for any of these heart problems? When: _____ Explain: _____
9. Have you had a recent stress test or other special heart test? When: _____ Where: _____
Results: _____
10. Have you ever been told you have high blood pressure? For how long? _____
11. Have you ever had a stroke or partial stroke? When: _____ Results: _____
12. Recreation drugs? When? _____ # of years? _____ Date Stopped: _____
13. Do you have problems with your lungs or chest?
 Past/ Present tobacco use? How many per day? _____ # years? _____ When quit? _____
 shortness of breath or cough productive of sputum?
 emphysema/ bronchitis/ asthma/ sleep apnea? (Circle) Any wheezing this week? _____
 ever been hospitalized for emphysema or asthma?
14. Have you had fever, chills, cold, or flu within the past week?
15. Do you have any problems with your: (Circle those which apply and give dates)
 liver (cirrhosis, hepatitis, jaundice, alcoholism)? _____
 kidneys (stones, infections, failure, dialysis)? _____
 blood (anemia, leukemia, sickle cell)? _____
 thyroid gland (over or under active)? _____
16. Have you ever been told you have sugar diabetes? For how long? _____
17. Do you have epilepsy or suffer from fits or seizures? For how long? _____
18. Do you have frequent heartburn/ indigestion, acid reflux from your stomach, or hiatal hernia?(Circle if applicable)
19. Have you ever had a blood transfusion? When? _____
20. Could you have any blood infections such as HIV or Hepatitis B/C?
21. Have you or any blood relatives ever had a serious bleeding problem (e.g. hemophilia, bruising)?
22. Do you have false teeth or oral jewelry? (Circle if applicable)
23. Do you have neck or back problems (e.g. arthritis in neck, herniated disc, surgery)?
24. Are you or could you be pregnant?
25. Date of your last period _____ Tubal? _____ Hysterectomy? _____
26. Would you like to be tested for possible pregnancy?
27. Do you have any other health problems? Explain: _____

Based on the information given by you certain additional tests may be ordered, i.e. drug screen, medication levels, chest x-ray, etc.

Patient Signature _____ Date _____ Time _____

BAYLOR REGIONAL MEDICAL CENTER AT GRAPEVINE

OR-0006 (Rev. 08/23/11)
ANESTHESIA QUESTIONNAIRE



**BAYLOR REGIONAL MEDICAL CENTER AT GRAPEVINE
PATIENT HEALTH INFORMATION REQUEST FORM**

**** Not a part of the permanent medical record****

At which of the following number(s) do we have permission to contact you?

- Home _____
- Cell _____
- Work _____
- Other _____

May we leave a message for you at work?

- Yes No

May we leave a message for you at home?

- Yes No

Other than you, whom may we talk to about your healthcare information?

- Spouse Name/Telephone _____
- Caretaker Name/Telephone _____
- Child Name/Telephone _____
- Parent Name/Telephone _____
- Other Name/Telephone _____

*Please indicate phone number where an approved contact may be reached during surgery

Do you have any health information that you would like kept confidential from any person or persons?

- Yes No

If so, please describe below:

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information

Patient or Personal Representative Signature

Date

Time

Printed Name

Relationship to Patient

MED REC NO. _____

PATIENT _____

PHYSICIAN _____

BILLING NO. _____

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