Monroe Surgical Hospital

PATIENT MEDICAL HISTORY

Office Use Only
Acct #: _____
TTA: _____

Patient Name_____ **Date of Birth**_____

Home phone: _____ Cell phone: _____

WHAT PROCEDURE ARE YOU SCHEDULED FOR? _____Date: _____

HEIGHT: _____ **WEIGHT:** _____

MEDICATION ALLERGIES / **ENVIRONMENTAL ALLERGIES**

Allergy	Reaction	Allergy (check all that apply)	Reaction
		□ Iodine □ X-ray dye □ Latex Allergy □ balloons □ Urinary catheter	
		□ Avocados □ Bananas □ Kiwi □ Chestnuts □ Shellfish □ Other food allergy _____	
		□ tape □ staples □ detergent □ mold/mildew □ animal dander □ chemicals □ other _____	

SENSITIVE SKIN OR ALLERGY TO HIBICLENS? □ YES □ NO

MODE OF ARRIVAL: □ Walked □ Wheelchair □ Stretcher □ Carried

DO YOU HAVE AN ADVANCED DIRECTIVE/LIVING WILL/POWER OF ATTORNEY? □ YES □ NO
****BRING COPY OF ADVANCED DIRECTIVES TO GO IN YOUR MEDICAL RECORD**

HEALTH ACCESSORIES:
□ Dentures □ Glasses □Contacts □ Hearing Aid □ Artificial Eye

I AM UNDER THE CARE OF THESE PHYSICIANS: _____

MEDICATIONS TAKEN IN LAST SIX MONTHS - CHECK ALL THAT APPLY:

□ Anesthesia
□ Cortisone
□ Blood Thinner/Aspirin
□ Tranquilizers
□ Pain Pills
□ Heart Medications
□ Chemotherapy
□ Radiation Therapy

CURRENT PHARMACIES USED: _____

FAMILY HISTORY: (PARENT, SIBLING, GRANDPARENT)

□ Heart Disease
□ Cancer
□ High Blood Pressure
□ Asthma
□ COPD
□ Diabetes
□ Any Family or Personal History of Malignant Hyperthermia

***PLEASE CHECK ALL THAT APPLY TO YOU (NOW OR IN THE PAST):**

EYES, EARS, NOSE AND THROAT

- Visual Problems
- Loose Teeth
- Dentures/Partials
- Frequent Sinus Infections
- Frequent Ear Infections
- Frequent Tonsillitis
- Hearing Problems

CARDIOVASCULAR

- Coronary Artery Disease
- Blood Pressure: High/Low
- Chest Pain/Angina
- Heart Attack Date: _____
- Irregular Heart Beats
- Blood Clots/Deep Vein Thrombosis (DVT)
- Peripheral Vascular Disease
- Valve Disease
- Pulmonary Edema
- Heart Failure (CHF)
- Defibrillator/Pacemaker
- Stent/Heart Cath_____
- Activity level: Able to climb 1 flight of stairs - Yes/No

RESPIRATORY

- Emphysema/COPD
- Asthma
- Recent Upper Respiratory Infection
- Tuberculosis
- Pulmonary Embolism (Blood Clot to Lung)
- Sleep Apnea
- Shortness of Breath
- Pneumonia
- Productive Cough
- Home Oxygen ___ Liters

GASTROINTESTINAL

- GI Bleed
- Reflux
- Gastric Ulcer
- Colitis
- Irritable Bowel Syndrome
- Diverticulitis/Diverticulosis
- Bowel Obstruction
- Colostomy/Ileostomy

GENITOURINARY

- Kidney stones
- Frequent UTI
- Incontinence
- Frequency
- Blood in urine
- Renal Insufficiency
- Dialysis
- Prostate problems
- Post-menopausal
- Urostomy
- LMP: _____ GYN: _____

NEUROLOGICAL

- Depression/Anxiety
- Migraines
- Dementia
- Weakness
- Tremors
- Numbness/ Tingling
- Stroke/TIA
- Vertigo/Dizziness
- Seizures Date of Last: ____
- Head Injury

MUSCULOSKELETAL

- Total Joint Replacement
- Amputee
- Prothesis
- Paralysis
- Arthritis
- Fibromyalgia

SKIN INTEGRITY

- Open Wounds/Ulcerations
- Rash/Sores
- Chronic Skin Condition
- Edema
- Skin Healing Problems
- Infusaport
- Dialysis Access
- Tattoos
- Skin Cancer

ENDOCRINOLGY

- Diabetes
- Pancreatitis
- Hypoglycemia
- Thyroid Problems

HEMATOLOGY/ONCOLOGY

- Bleeding Disorders
- Anemia
- HIV/AIDS
- Hepatitis
- Previous Blood Transfusion Date: _____
- History of Transfusion Reaction
- Radiation
- Date of Last Treatment: __
- Chemotherapy
- Date of Last Treatment: __
- Cancer (Type): _____

PREVIOUS SURGERIES

- CABG
- Appendectomy
- Hernia Repair
- Gallbladder
- Tubal Ligation
- Hysterectomy
- Carpal Tunnel Release
- Prostate Surgery
- Cataract
- None

INFECTION CONTROL

□ Recent infection or illness in the past 48 hours?
□ Infection from previous surgery in the last 6 months?
□ Hospitalized in the last year?

□ Have you ever been told that you have had MRSA infection? Date_____

COVID-19 screening

□ Cough □ Difficulty breathing □ New loss of taste/smell
□ Sudden shortness of breath □ Sore throat
□ **Positive COVID-19 test in the last 10 days?**

Vaccinations

□ Flu shot during this current year's flu season (October-March)
□ Pneumonia shot within last 5 years (65 and older)
□ COVID-19 vaccine
□Hepatitis B vaccine (series of 3)
□Childhood vaccinations up to date
□Unknown vaccination history

SOCIAL HISTORY

□ **Tobacco use**	□ Chews □ Dips □ Smokes □ Vapes	Number of years smoked: _____ Number of pack(s)/day: _____ Year quit smoking: _____
□ **Alcohol use**	□ Beer □ Wine □ Liquor	Amount: _____ Frequency: _____
□ **Recreational Drug Use**	□ Marijuana □ Meth □ Cocaine □ Heroin	Frequency: _____ Last used: _____

PSYCHOSOCIAL ASSESSMENT

Marital Status	□ Married □ Single □ Widowed
Employment Status	□ Full Time □ Part Time □ Retired □ Unemployed
Highest level of Education	□ High School □ College □ Other:
Do you live alone?	□ Yes □ No Who do you live with? _____ Relationship: _____

SOCIAL NEEDS SCREENING

FOOD	In the past year, have you had to use the Food Bank/Soup Kitchen?	□ Yes □ No
UTILITIES	In the past year, has the electric, gas, oil, or water company threatened to shut off your services in your home?	□ Yes □ No
HOUSING	Do you think you are at risk for becoming homeless?	□ Yes □ No
TRANSPORTATION	In the past year, have you ever had to go without health care because you didn't have a way to get there?	□ Yes □ No
SAFETY	Does anyone in your home physically or verbally hurt you?	□ Yes □ No
MENTAL HEALTH	In the past few weeks, have you wished you were dead, or having thoughts of killing yourself?	□ Yes □ No

Anticipate Needing Help After Discharge?

□ Home Health Assistance? Name of Agency: _____

□ Assisted Living Center? Name of Center: _____

□ Hospice? Name of Agency: _____

□ Nursing Home? Name of Facility: _____

Check All Equipment That You Have at Home:

□ Wheelchair □ Walker □ Hospital Bed □ Bedside Commode □ Shower Seat

□ CPAP □ BIPAP □ Nebulizer □ Home Oxygen

□ Medical Equipment Company? Name of Company: _____

HAVE YOU FALLEN IN THE LAST 6 MONTHS? □Yes □No

PLEASE LIST MEDICATIONS OR ATTACH A LIST OF CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	LAST DOSE TAKEN

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

According to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Monroe Surgical Hospital is only allowed to discuss your medical condition or treatment with your permission. We know that you may have family members or other close friends who contact us to check on you during your stay with us. To better serve you, please list any individuals you consent for us to discuss your medical condition or treatment.

FAMILY MEMBER(S) OR FRIENDS(S) WITH WHOM WE MAY DISCUSS YOUR MEDICAL CONDITION OR TREATMENT:

Name	Relationship	Phone number
Name	Relationship	Phone number
Name	Relationship	Phone number
Name	Relationship	Phone number
Name	Relationship	Phone number

I consent to communication regarding my medical condition or treatment with the individual(s) named above.

Patient's Name (printed)	Patient's Date of Birth
Patient's Signature	Today's Date

MonroeSurgical Hospital

PATIENT PORTAL & PROXY ACCESS

_____ NEW ENROLLEE _____ PROXY ACCESS

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ____/_____/_____
LAST FIRST M.I.

Address: _____
Street Address City State Zip Code

Email Address: _____ (Personal email address only, please)

I have read and understand the Monroe Surgical Hospital Patient Portal Information document. I understand the risks and benefits of patient portal and agree that I understand the risks associated with online communications between the hospital and the patient. I consent to the conditions outlined in the Patient Portal Information document. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Monroe Surgical Hospital should I decide against using the patient portal.

_____ _____
Patient Signature Date

PROXY INFORMATION (Person to whom you authorize Monroe Surgical Hospital to release Patient Portal access)

Proxy Name: _____ Date of Birth: ____/_____/_____
LAST FIRST M.I.

Address: _____ Phone: _____
Street Address City State Zip Code

Email Address: _____ (Personal email address only, please)

Please Indicate the Proxy Access outlined below that describes the proxy access requested:

_____ ***Adult*** – Patient must sign this form to provide authorization for release of his/her medical information. Proxy access valid until revoked by the patient.

_____ ***Legal Guardian of Adult Patient*** - Legal guardian by court order, Power of Attorney for Health Care, or other legal arrangement. A copy of the legal document must accompany this request form. You must notify Monroe Surgical in case of any change in authority.

_____ ***Minor Patient*** – Must have parental rights or legal guardianship rights. If a guardianship exists, this request must be accompanied by a copy of the court order appointing the guardian. Information regarding reproductive health, STDs, mental health, and/or substance abuse will only be made available to a parent or guardian with consent of the minor patient.

By signing below, I acknowledge and agree that:

- I will be using my own Patient Portal account to access the patient's portal account.
- I will comply with the conditions outlined in the Patient Portal Information document.
- The patient can revoke my access to his/her Patient Portal account at any time

_____ _____
Proxy Signature Date

_____ _____
Patient Signature (if applicable) Date