Mount Sinai
The Mount Sinai Hospital
One Gustave L. Levy Place
New York, NY 10029

Patient Admission Database / Preoperative Services

Fax Completed Form to 212-659-8328

A. PATIENT INFORMATION

Last Name:	First Name:	MI:	Date of Birth: / /

Sex: ☐ Male ☐ Female

Language(s) Spoken: ☐ English ☐ Spanish ☐ Other _____

If you are not the patient but are filling this form out on behalf of the above patient what is:
Your Name: Your Relationship to Patient:

• Please give us a number or email address where we are permitted to contact you:

Home Phone #:	Mobile Phone #:	Work Phone #:	Email:

• Who is your primary health care provider / medical doctor / GP / internist / pediatrician?

Name:	Phone #:	When were you last seen by him/her?

If you are going home on the day of surgery, who will escort you home when you are discharged?
Name: Phone #: ( )

• Expected Date of Surgery: / /

• What procedure/surgery will you be having?

• On which side of your body? (if applicable) ☐ Both Sides/Bilateral ☐ Left ☐ Right

• Why are you having your procedure? What is your diagnosis?

• Your Surgeon's Name:

B. GENERAL HEALTH

Height: ____ feet ____ inches (____cm) Weight: _____ lbs (_____kg)

• What is the most physical activity are you able to perform?
☐ No real limitations (fully active; can play vigorous sports)
☐ Can climb a flight of stairs or climb a hill
☐ Can walk short distances
☐ Unable to walk (confined to wheelchair or bed)

• What, if anything, limits your physical activity?
☐ Difficulty breathing
☐ Chest pain
☐ Knee/hip pain/arthritis
☐ Leg/buttock muscle pain/cramps
☐ Fatigue/tire easily
☐ Other _____

• Do you need help at home with any of the following? ☐ Bathing ☐ Toileting ☐ Walking ☐ Eating ☐ Dressing ☐ Grooming

C. ALLERGIES TO MEDICATIONS, FOODS, & SUBSTANCES

• What bad reactions to medications, foods, and substances do you have? (e.g. rash, nausea, unknown, etc.) ☐ **I have no allergies**

Allergy TO:	Reaction:	Allergy TO:	Reaction:
1.		3.	
2.		4.	

D. SOCIAL HISTORY & DIET

• Describe your smoking history: ☐ I have never smoked ☐ I currently smoke ☐ I am an ex-smoker (# Years Smoke-Free:_____)

• Describe your alcohol use: How many glasses of wine/beer/liquor do have per day? (circle) <1 - 1 - 2 - 3 - 4 - 5 - 5+

• Do you have any dietary restrictions? ☐ Kosher ☐ Vegetarian ☐ Low Salt ☐ Low Fat ☐ Organic ☐ Gluten free ☐ Dairy free ☐ Diabetic ☐ Other_____

E. SURGERY & ANESTHESIA HISTORY

• Have you had any of the following types of surgery or procedures? ☐ **I have never had surgery**

Head/Neck: ☐ Brain ☐ Eyes ☐ Nose ☐ Tonsils ☐ Thyroid ☐ Throat ☐ Other _____
Chest: ☐ Heart ☐ Lungs ☐ Breast ☐ IV Catheter / Port Implant ☐ Esophagus ☐ Aorta ☐ Other_____
Abdomen: ☐ Gall Bladder ☐ Appendix ☐ Colon ☐ Liver ☐ Stomach ☐ Kidney ☐ Pancreas ☐ Other_____
Pelvis: ☐ Hernia ☐ Uterus/Ovaries ☐ C-Section ☐ Bladder ☐ Prostate ☐ Other_____
Extremities: ☐ Knee ☐ Hip ☐ Shoulder ☐ Hand/Wrist ☐ Arteries/Veins ☐ Other_____

• Did you have any problems with the anesthesia for any of those surgeries? ☐ **I have not had problems with anesthesia**

☐ Nausea and/or Vomiting	☐ Muscle Aches	☐ Sore Throat
☐ Uncontrolled post-operative pain	☐ Damaged Teeth	☐ Eye Pain
☐ Awareness or memories of surgery	☐ Back Pain	☐ Headache
☐ Difficulty having breathing tube inserted	☐ Long time to get back to "normal"	☐ Malignant hyperthermia
☐ Pseudocholinesterase deficiency	☐ Delirium/Confusion	☐ Other _____

• Do any blood relatives have problems with anesthesia that you are aware of? ☐ No ☐ Yes (please explain):

F. DENTAL HISTORY

• Do you have any of the following? ☐ **I have no dental problems**

☐ Loose Teeth	☐ Bridges	☐ Temporomandibular Joint Disease (TMJ)
☐ Chipped Teeth	☐ Dentures	☐ Caps / Veneers

G. GASTROINTESTINAL DISEASE HISTORY

• Do you have a history of any of the following liver or intestinal problems? ☐ **I have no liver or intestinal problems**

☐ Acid reflux (GERD) / heartburn	☐ GI bleeding / rectal bleeding	☐ Pancreatitis	☐ Cirrhosis of liver
☐ Inflammatory bowel disease (Crohn's disease, ulcerative colitis)	☐ Stomach / duodenal ulcer	☐ Esophageal varices / vomiting blood	
	☐ Irritable bowel syndrome	☐ Stool incontinence	☐ Hiatal hernia
☐ Problems swallowing or digesting	☐ Diarrhea / Constipation	☐ Jaundice	☐ Gallstones

• When was your last colonoscopy screening? _____ ☐ I have never had a colonoscopy

H. HEART DISEASE HISTORY

Who is your cardiologist? (If applicable)
Name: | Phone #: | When were you last seen by him/her?

• Do you have a history of any of the following heart or blood vessel problems? ☐ **I have no heart or blood vessel problems**

☐ High blood pressure / hypertension	☐ Heart failure (CHF)
☐ High cholesterol / Hyperlipidemia	☐ Congenital heart disease
☐ Heart attack / myocardial infarction (MI) (Approximate date:_____)	☐ Coronary artery blockages
☐ Heart Surgery or Coronary Stents (Approximate date:_____)	☐ Blood clots
☐ Abnormal heart rhythm / Implanted defibrillator (AICD) / Pacemaker	☐ Heart valve disease / Heart murmur
☐ Aneurysm or peripheral vascular disease	

I. RESPIRATORY/LUNG DISEASE HISTORY

Who is your lung doctor (pulmonologist)? (If applicable)
Name: | Phone #: | When were you last seen by him/her?

• Do you have a history of any of the following lung / breathing problems? ☐ **I have no lung or breathing problems**

☐ Emphysema / bronchitis / COPD (Do you use oxygen at home? ☐ Yes ☐ No)	☐ Sleep apnea (Do you use CPAP at home? ☐ Yes ☐ No)
☐ Asthma: ☐ mild ☐ moderate ☐ severe	☐ Tracheostomy (currently or in the past)
☐ Chronic cough	☐ Pulmonary embolus / blood clot in lungs
☐ Sinusitis / seasonal allergies / nasal congestion	☐ Sarcoidosis or pulmonary fibrosis
☐ Fluid around lung / pleural effusion	☐ Pulmonary hypertension
☐ Recent upper respiratory tract infection (cold, flu, runny nose, etc.)	

J. PSYCHIATRIC HISTORY

• Do you have a history of any of the following psychiatric / mental disorders? ☐ **I have no psychiatric history**

☐ Depression	☐ Bipolar Disorder	☐ Post-traumatic stress disorder (PTSD)
☐ Anxiety / Panic Attacks	☐ Claustrophobia	☐ Schizophrenia

K. UROLOGIC & GYN DISEASE HISTORY

• Do you have a history of any of the following urologic or gynecologic problems? ☐ **I have no urologic or gyn problems**

☐ Kidney insufficiency or failure / Chronic Kidney Disease Dialysis: ☐ Hemodialysis ☐ Peritoneal Dialysis	☐ Difficulty Urinating ☐ Frequent/Urgent Urination ☐ Urine incontinence	☐ Kidney stone / Urinary stones

Women: Do you think you are you currently pregnant? ☐ Yes ☐ No If yes, how many weeks? _____
When was your last mammogram or breast exam? _____ ☐ I have never had a mammogram
Do you have a history of any of the following?
☐ Endometriosis ☐ Peri-menopausal symptoms (e.g. hot flashes) ☐ Abnormal vaginal bleeding

Men: When was your last prostate exam? _____ ☐ I have never had a prostate exam
Do you have an enlarged prostate? ☐ Yes ☐ No ☐ Unknown

Children: ☐ Toilet Training in Progress ☐ Wears Diapers ☐ Wears Diapers at night ☐ Fully Toilet Trained

L. NERVOUS SYSTEM DISEASE HISTORY

• Do you have a history of any of the following nervous system problems? ☐ **I have no nervous system problems**

☐ Vision loss Do you wear contacts / glasses? ☐ Yes ☐ No	☐ Stroke / Mini-stroke / TIA (Approximate date:_____)	☐ Headaches / Migraines ☐ Motion sickness
☐ Hearing loss Do you wear a hearing aid? ☐ Yes ☐ No	☐ Nerve problems / neuropathy ☐ Fainting / Vertigo / Dizziness	☐ Myasthenia gravis ☐ Multiple sclerosis
☐ Seizure / Epilepsy / Fits (Approximate date of last seizure:_____)	☐ Complex Regional Pain Syndrome ☐ Developmental delay	☐ Spinal cord injury ☐ Parkinsons disease
☐ Dementia / Alzheimer's disease	☐ Cerebral palsy	☐ Muscular dystrophy
☐ Attention deficit hyperactivity disorder / ADHD	☐ Autism	☐ Down Syndrome
☐ Glaucoma		

M. BLOOD, INFECTIOUS & IMMUNE SYSTEM DISEASE HISTORY

• Do you have a history of any of the following blood, infectious, or immune system problems? ☐ **I have no blood, etc. problems**

☐ Hepatitis B/C (HBV, HCV)	☐ HIV	☐ Anemia / low blood counts (Have you ever received a blood transfusion? ☐ Yes ☐ No)
☐ Chicken Pox / Shingles	☐ Lupus	
☐ Sickle cell disease / trait	☐ Scleroderma	☐ Thrombocytopenia / low platelets
☐ Fevers / Night sweats	☐ Eczema	☐ Hemophilia or other clotting disorder / easy bruising or bleeding
☐ Unintended weight loss	☐ Psoriasis	☐ Neutropenia / low white cells

• Have you ever been placed on contact isolation or had an antibiotic resistant infection? ☐ Yes ☐ No	• Have you had the following immunizations? ☐ Flu shot (date:_____) ☐ Pneumovax (date:_____)

N. GLAND DISEASE HISTORY

• Do you have a history of any of the following conditions? ☐ **I have no gland problems**

☐ Diabetes	☐ Parathyroid disease	☐ Adrenal disease	☐ Carcinoid Syndrome
☐ Hyperthyroidism	☐ Hypothyroidism	☐ Pituitary disease	☐ Pheochromocytoma

O. BONE, JOINT & SKIN DISEASE HISTORY

• Do you have a history of any of the following bone, skin or joint problems? ☐ **I have no bone, joint, or skin problems**

☐ Back pain / herniated disks / slipped disks	☐ Rheumatoid arthritis	☐ Chronic neck pain
☐ Osteoarthritis / Degenerative Joint Disease	☐ Osteoporosis	☐ Fibromylagia
☐ Scoliosis / Kyphosis / Spine abnormalities	☐ Ankylosing spondylitis	☐ Keloids

P. CANCER HISTORY

• Have you ever had cancer? ☐ Yes ☐ No If yes, what type of cancer? _____	If you have had cancer, have you been treated with any of the following? ☐ Radiation ☐ Chemotherapy ☐ Surgery

Q. OTHER MEDICAL HISTORY

• Please comment on any other relevant medical history not described above:

The information provided is true to the best of my knowledge and I understand that it will be reviewed and modified for accuracy as necessary by a member of the medical center staff.

Name (Print) _____ Signature_____ Date/Time_____

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I have reviewed the information provided with the patient (or patient representative) and have verified, appended, and/or modified the information for accuracy as necessary.

Reviewed By (Print)_____(RN) Signature_____Date/Time_____