New York Eye and Ear Infirmary of Mount Sinai

ADM SELFASSESS

# Pre-Admission Adult Patient Self-Assessment

Surgeon: _____

Date of Surgery: _____/_____/_____

Date Form Completed: _____/_____/_____

Please fill out ALL 4 pages as completely as possible. A clinician will review this information with you before your surgery.

*If you have had surgery at NYEE in the past 30 days, please complete only the top portion of this form and note any other changes in your health since your last visit.*

| | |
|---|---|
| **Last name:** | **First name:** |
| **Have you been a patient at New York Eye and Ear Infirmary of Mount Sinai in the past?** ☐**Yes** ☐**No**<br>If yes, date: ____/____/_____ | **If previous patient, has your name changed since last visit?** ☐**Yes** ☐**No**<br>*If yes, what was your previous name?* |
| **Primary or native language**<br>☐English ☐Spanish ☐Chinese-Mandarin ☐Chinese-Cantonese ☐Russian ☐Sign Language ☐other:_____<br>**Preferred language to discuss health information**<br>☐English ☐Spanish ☐Chinese-Mandarin ☐Chinese-Cantonese ☐Russian ☐Sign Language ☐other:_____ | **Will you require a language interpreter?**<br>☐**Yes** ☐**No** |
| Date of Birth (MM/DD/YYYY)<br>_____/_____/_____ Age:_____ | Gender: ☐Male ☐Female |
| Height:_____ feet ____inches Weight:_____lbs. | |
| **Name of Person (Escort) who will take you home after surgery:** | **Escort Contact Phone #:**<br>(_____) _____ – _____ |

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|---|---|
| **ALCOHOL USE** | |
| **Frequency** | ☐Never ☐Current Every day ☐Current Some days ☐Former |
| **Type of alcohol** | ☐Hard Liquor ☐Beer ☐Wine |
| **DRUG/SUBSTANCE USE** | |
| **Frequency** | ☐Never ☐Current Every day ☐Current Some days ☐Former |
| **Type of drug/substance** | |
| **Method** | |
| **TOBACCO USE** | |
| **History of Tobacco use** | ☐Never smoked ☐Former cigarette smoker: Date quit: _____<br>☐Cigarette smoker ☐Every day ☐Some days Cigarettes per day: _____ ***OR*** Packs per day:_____<br>Cigar/Pipe Smoker: ☐Yes ☐Light ☐Heavy Years Tobacco use (any type): _____ |
| **ANESTHESIA HISTORY** | |
| **Do you have a history of problems with anesthesia?**<br>☐**No** ☐**Yes** | **Has a family member had a history of problems with anesthesia?**<br>☐**No** ☐**Yes** |

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## MEDICAL HISTORY

| | | |
|---|---|---|
| **Eye Problems** | ☐ No | ☐ Cataract ☐ Loss of vision ☐ Eye Injury ☐ Glaucoma ☐ Other: _____<br>Eye Surgery: List all: _____ |
| **Ears/Nose/Throat Problems** | ☐ No | ☐ Sore Throat ☐ Tonsils Removal ☐ Adenoids Removal ☐ Ear Tubes (Myringotomy) ☐ Sinus problems<br>☐ Recent or recurring Bloody Nose (Epistaxis) ☐ Other: _____ |
| **Teeth (Dental)** | | ☐ All intact ☐ Loose ☐ Missing ☐ Chipped ☐ Caps ☐ Full Dentures ☐ Partial Dentures |
| **Neuro/Brain Problems** | ☐ No | ☐ Stroke Date: _____ ☐ Head trauma Date: _____<br>☐ Seizure History ☐ Parkinson's disease ☐ Dementia/Alzheimer's Disease ☐ Multiple Sclerosis ☐ Developmental Delay<br>☐ Other: _____ |
| **Cardiac/Heart Problems** | ☐ No | ☐ Congestive Heart Failure ☐ Hypertension ☐ Heart Attack Date: _____<br>☐ Blood Clot/Phlebitis ☐ High Cholesterol ☐ Murmur ☐ Aneurysm ☐ Other heart disease: _____<br>☐ Arrhythmia ☐ **Implantable Cardiac Device** ☐ **Pacemaker** ☐ **Defibrillator** If yes: date of last interrogation: _____<br>☐ **Heart Surgery:** ☐ Bypass (CABG) ☐ Valve ☐ Other: _____ |
| **Respiratory/Lungs/ Breathing Problems** | ☐ No | ☐ Asthma ☐ Emphysema ☐ Respiratory Infections ☐ TB ☐ Wheezing ☐ Pneumonia/Flu ☐ Sleep Apnea<br>Other: _____<br>☐ **Oxygen Use** **If yes:** ☐ **As needed** ☐ **Continuous** |
| **Stomach/Kidney/ Liver Problems** | ☐ No | ☐ Kidney Disease ☐ Hemodialysis; Last date of dialysis: _____<br>☐ Liver Disease ☐ Hepatitis ☐ Stomach Disease ☐ Other: _____ |
| **Reproductive Problems** | ☐ No | **Cancer:** ☐ Breast ☐ Cervical ☐ Uterine ☐ Testicular ☐ **Surgery:** ☐ Breast ☐ Prostate ☐ Other: _____<br>**Women only:** ☐ Pregnant ☐ Breastfeeding Date of last menstrual period: _____<br>☐ Herpes ☐ Sexually Transmitted Disease: _____ |
| **Bone/Joint/ Muscle Problems** | ☐ No | ☐ Arthritis ☐ Rheumatoid arthritis ☐ Myasthenia Gravis ☐ Muscular Dystrophy<br>☐ Other: _____<br>☐ Joint surgery/Replacement/Implant: _____ |
| **Diabetes** | ☐ No | ☐ Insulin Use ☐ Oral med/Pill Controlled ☐ Diet Controlled<br>Last Blood sugar reading if known: _____ Last Hg-AIC if known: _____ |
| **Endocrine/ Hormone Problems** | ☐ No | ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Hormone disorder/therapy<br>☐ Other: _____ |
| **Hematologic/ Blood Problems** | ☐ No | ☐ Anemia ☐ Clotting problems ☐ Sickle Cell ☐ Hemophilia ☐ Leukemia ☐ Lymphoma ☐ Low platelet count<br>☐ Other: _____ |
| **Psychosocial Problems** | ☐ No | ☐ ADHD ☐ ADD ☐ Autism Spectrum Disorders<br>☐ Depression ☐ Anxiety ☐ Bipolar ☐ Post traumatic Stress Disorder<br>Thought disorders: ☐ Schizophrenia ☐ Psychosis ☐ Other: _____ |

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| | | |
|---|---|---|
| **Skin/ Integumentary Problems** | ☐ **No** | ☐ Eczema ☐ Psoriasis ☐ Rash ☐ Shingles ☐ Herpes ☐ Pressure Ulcers ☐ Wounds/Recent surgical Incision<br>☐ Other: _____<br>☐ **Body Piercings:** _____ **NOTE: ALL Piercing jewelry MUST be removed before arriving for surgery**<br>☐ **AV Fistula** ☐ **Mediport** ☐ **PICC line** |
| **Infectious Disease Problems** | ☐ **No** | ☐ AIDS/HIV ☐ MRSA ☐ Antibiotic resistant infection (VRE)<br>☐ Other: _____ |
| **Cancer:** *If* not previously *listed* | ☐ **No** | Site: _____<br>Treatment: _____ |
| **Surgical history** *If* not previously *listed* | ☐ **No** | |
| **Any additional medical information you think is important to share** | ☐ **No** | |

## ALLERGIES

☐ **No** ☐ **Yes** ☐ **Latex**

If Yes: Please list all Medication, Food and Environmental allergies and reactions below.

| Name | Reaction/Comments |
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**MEDICATION LIST**

**LIST CURRENT MEDICATIONS:** List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

| Medication (Brand and Generic Name) | Dose | How you take the medication *and* How Often You Take the Medication |
|---|---|---|
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**I certify that the information provided is as correct and complete as possible.**

**Patient:**_____ **Date:**_____ **Time:**_____

**Person completing form if other than patient:**_____ **Date:**_____ **Time:**_____