# WAYNE HOSPITAL
# PRE-ADMISSION/PATIENT HISTORY FORM

Name: ________________________________________ Date: ______________________

Please help us to serve you better by completing this two-sided form as accurately as possible.

Chief Complaint / Procedure ________________________________________
Emergency Contact (important phone numbers)
Name: ________________________________ Phone: ______________
Name: ________________________________ Phone: ______________

## Advance Directives:

☐ Durable Power of Attorney for Health Care ☐ Living Will ☐ On File
☐ Request information ☐ Decline information

Are you a smoker? ☐ Yes ☐ No # packs per day ______

Do you take any medications? (include herbal medications, vitamins, minerals over the counter medications, supplements, birth control pills, and chemotherapy)

| Name of Medication | Dose | How often? | Last Dose | Name of Medication | Dose | How often? | Last Dose |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Do you have any allergies? (medications, environment, foods, tape, betadine, iodine)
☐ No known allergies   Allergies, please list:

| Substance | Reaction | Substance | Reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Food Allergies: None ________ Milk_______ Strawberries ________ Shellfish _______
Eggs_________ Chocolate _________ Other __________

Food Dislikes: None _______ Eggs _______ Chicken _______ Milk ______ Fish _______

Other Allergies: None _______ Bleach _______ Detergents _______ Latex _______ Tape _______
Other _______________

**Safety in the Environment**: ______ None noted

Physical Abuse __________
Verbal Abuse __________
Emotional Abuse _________
Other ______________

Sexual Abuse ______________
Unsafe Living Conditions ____________
Change in the Living Environment __________

## Alcohol Use / Drug Use:

Denies or None ________
Beer_______ # daily
Wine ______ # daily
Marijuana _________
Cocaine __________

**Cardiac / Heart History**: None_________

Arrhythmia _________
CHF _______
Hypertension ________
Pacemaker ___________
CABG _____#vessels
Heart Attack _________
Hypotension _________
Palpitations __________
Chest pain / Angina _______
High Cholesterol / Triglycerides ______
Murmur / Valve Problems ___________
Angioplasty / Cath _________

**Breathing / Respiratory History**: _______None

Asthma _______
COPD ________
Tuberculosis _________
Bronchitis ________
Emphysema ______
Pneumonia _________
Chronic cough ______
Sleep Apnea ______
Other ________

**Medical History:** None _________

Diabetes _____
Kidney/Bladder infections _____
Blood Disorders / Anemia _____
Hemorrhage ______
Sleep problems ________
Anxiety _________
Last Period __________
Thyroid problem ________
Hepatitis / Type _________
Leukemia _________
Phlebitis _________
Mental illness ___________
Sexually Transmitted Disease ______
Seizures ________
Kidney / Bladder Stones ______
Liver Problems / Jaundice ______
Clotting / DVT problems ________
Stroke ________
Depression ___________
Pregnant ______
Cancer ______________ Location ______________
Flu Vaccine, date rec'd ___________________
Pneumonia Vaccine, date rec'd _____________

**Medical History cont.**

Crohn's Disease ________ Irritable Bowel Syndrome ________ Hiatal Hernia ______
Heartburn / Indigestion ______ Ulcer ______ Acid Reflux _______
Diverticulitis _______

**Surgical History:**

Name of Procedure Date (if known)

_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________

**Family History:**

Heart Problems ______ Respiratory / Breathing Problems ________
Diabetes _______ Cancer __________ Other ________________

**X-ray History:**

Contrast / Dye used in past 48 hours yes______ no_______
Use Glucophage yes ______ no _______

Do you need assistance with activities of daily living? Yes / No

If so, describe ______________________________________________________________________

_________________________________________________________________________________

Information obtained from:

☐ Patient ☐ Family ☐ Hospital / Nursing facility ☐ Chart

Signature: _________________________________ Date _______________ Time ___________

Wayne Hospital
835 Sweitzer Street
Greenville, OH 45331
PAT Phone: 547-5695 (Sharlynn Hickey)
Fax: 937-547-5783