The Heart Hospital
Baylor Plano
Joint ownership with physicians

ADMISSION INTAKE FORM

(Not part of the permanent medical record)

Patient Name: _____

Date of Birth: _____ Ht: _____ Wt: _____

Do you have a Mediport/PICC line/ additional access? ☐ No ☐ Yes

Do you have any of the following allergies? If yes please list reaction to allergen.

Food Allergy: ☐ No ☐ Yes: List allergen with reaction: _____

Drug Allergy: ☐ No ☐ Yes: List allergen with reaction: _____

_____

Latex Allergy: ☐ No ☐ Yes: List reaction: _____

Primary Language: _____ Do you need an interpreter? _____

Did you arrive from: ☐ Home ☐ Emergency Department ☐ Clinic ☐ Extended Care Facility

☐ Rehabilitation ☐ Other (specify):_____

Do you have any of the following characteristics:

☐ Been hospitalized within the last year ☐ Currently on dialysis ☐ Past history of MRSA

Do you **CURRENTLY** have any of the following: ☐ None Apply

☐ Open Wound ☐ Diarrhea ☐ Indwelling catheter ☐ Pressure Ulcer ☐ Vascular Access

Do you have an advance directive? ☐ No ☐ Yes Type (check all that apply):

☐ Power of Attorney ☐ Living Will ☐ Mental Health Directive ☐ Out of Hospital Do Not Resuscitate

Where is your directive located? _____

What does your advance directive say your wishes are?

_____

_____

If we are unable to speak with you as a result of your illness, who should we speak with on your behalf?

Name: _____ Relationship: _____ Phone #: _____

Have you ever received blood or blood products? ☐ No ☐ Yes If yes, year received and where? _____

Have you ever had any of the following (Please check ALL that apply): ☐ None Apply

☐ Abdominal Aortic Aneurysm
☐ Alzheimer's
☐ Heart Attack
☐ Amputation:
Location_____
☐ Anemia
☐ Angina/Chest pain
☐ Arthritis:
Location_____
☐ Asthma
☐ Auto Immune
☐ Disorder/Disease:
Type: _____
☐ Back Pain:
Upper/Middle/Lower
☐ Bleeding Disorder:
Type: _____
☐ Blood disorder:
Type: _____
☐ Cancer: Type:_____
Location: _____
Treatment_____
☐ Cataract
☐ Cerebral Palsy
☐ Chronic Fatigue Syndrome
☐ COPD/Chronic Bronchitis
☐ Cochlear Implants
☐ Colitis
☐ Congestive Heart Failure
☐ Constipation
☐ Coronary Artery Disease
☐ Crohn's Disease
☐ CVA (Stroke/TIA)
☐ Deep Vein Thrombosis (DVT)
☐ Dementia
☐ Dental Cavities
☐ Diabetes Insulin Dependent
☐ Diabetes Non-Insulin Dependent
☐ Dialysis: Hemo/Peritoneal: MWF/TTHS
☐ Diverticulitis
☐ End Stage Renal Disease
☐ Fainting
☐ Fibromyalgia
☐ Gallstones
☐ GERD
☐ Gastrointestinal Bleeding
☐ Glaucoma
☐ Gum Infection
☐ Head Injury
☐ Hemorrhoids
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Hernia
☐ High Cholesterol
☐ High Risk Pregnancy
☐ HIV/AIDS
☐ High Blood Pressure
☐ Irregular Heart Rate:
Explain: _____
☐ Irritable Bowel Syndrome
☐ Kidney stones
☐ Liver Disease
☐ Meniere's
☐ Meningitis
☐ Migraine
☐ Neuropathy
☐ Nose Bleeds
☐ Palpitations
☐ Pancreatitis
☐ Parkinson's
☐ Peptic Ulcer
☐ Pneumonia
☐ Psychiatric:
Explain: _____
☐ Pulmonary Embolism
☐ Rheumatoid Arthritis
☐ Sickle Cell
☐ Seizures
☐ Sleep Apnea: CPAP/BIPAP
☐ Stroke
☐ Thyroid: Low/High
☐ Transplant: _____
☐ Traumatic Brain Injury
☐ Ulcer
☐ Ulcerative Colitis
☐ Urinary Tract Infection
☐ Other:_____

For Women Only:

Are you: ☐ None Apply ☐ Pregnant ☐ Menstruating ☐ Menopausal ☐ Unknown

Date of last menstrual period: ___/___/___ Have you had a hysterectomy? ☐ No ☐ Yes

Have you had a mastectomy (circle)? ☐ No ☐ Yes If yes specify which side: ☐ Right ☐ Left

Are you breast-feeding or lactating? ☐ No ☐ Yes

Number of times you have been pregnant: _____ Number of children: _____ Abortion: _____

Please list ALL Surgeries with Dates: ☐ Never Had Surgery

_____

_____

_____

_____

Do you have any implants (please check all that apply): ☐ None Apply

- ☐ Aneurysm Stent or Aneurysm Clip
- ☐ Artificial Heart Valve
- ☐ Artificial Limbs
- ☐ Coronary Stents (Drug Coated/Bare Metal/Unknown)
- ☐ Renal or Other Stents
- ☐ Prosthetic Eye
- ☐ Middle Ear Prosthesis
- ☐ Implanted Devices/Pumps/Stimulator
- ☐ Metal Implants
- ☐ Joint Replacement (specify):_____
- ☐ Lens Implants
- ☐ Pins/Rods/Screws (specify): _____
- ☐ Pacemaker/ICD
- ☐ Penile Implant
- ☐ Tracheotomy
- ☐ Body Art
- ☐ Body Piercing
- ☐ Gastric Band
- ☐ Other (please specify):_____

Have you had a previous adverse reaction to anesthesia? ☐No ☐ Yes

If yes specify: _____

_____

If DIABETIC please answer the following: ☐None Apply

Type of Diabetes: ☐ Type I ☐ Type 2

Date of onset: ☐ New Onset ☐ 1-5 years ☐ Greater than 5 years

Do you monitor your blood sugar at home? ☐No ☐Yes

Do you know the symptoms of low blood sugar? ☐ No ☐ Yes

Do you follow a meal plan? ☐ No ☐ Yes

Do you understand foot care for diabetics? ☐ No ☐ Yes

Do you know how to administer oral hypoglycemic medications? ☐ No ☐ Yes

Are able to administer insulin properly? ☐ No ☐ Yes

Do you know what to do, when you are sick, to manage your diabetes? ☐ No ☐ Yes

Do you have an activity or exercise plan? ☐ No ☐ Yes

Vaccines:

Please list **dates** of last dose on the following vaccines: ☐ Unknown

Tetanus_____ Hepatitis _____ Flu_____ Flu, N1H1_____ Pneumococcal Vaccine_____

Living Environment Screening:

Do you live alone? ☐ Yes ☐ No If no with whom:

☐ Children ☐ Friend ☐ Grandparents ☐ Parents ☐ Spouse ☐ Significant Other

☐ Other (specify):_____

Do you care for someone in the home? ☐ No ☐ Yes If yes whom:

☐ Children ☐ Friend ☐ Parent ☐ Pet ☐ Significant other ☐ Spouse ☐ Other (specify) _____

Anticipated changes because of illness: ☐ None ☐ Inability to care for self

☐ Inability to care for someone else ☐ Inability to work ☐ Other (specify) _____

Who will be helping you with your care when you leave?

Name_____ Relationship_____ Phone #_____

Describe your living conditions:

☐ Apartment ☐ Assisted Living ☐ Extended Care Facility ☐ Foster Care ☐ House ☐ Homeless

☐ No Permanent Address ☐ Other (specify) _____

Do you have resources to obtain your medication? ☐ No ☐ Yes

Do you currently use a home care agency? ☐ No ☐ Yes If yes please specify _____

Functional Screening:

In the past **4 weeks** have you had any significant decrease in function in the following areas:

☐ No changes in the activities of daily living within the last 2 to 4 weeks

☐ Walking ☐ Transferring ☐ Toileting ☐ Bathing ☐ Dressing ☐ Self-Feeding ☐ Swallowing

☐ Communication ☐ Other (specify) _____

Assistive Equipment Used for Home: ☐ No ☐ Yes If yes please specify:

☐ Cane ☐ Commode ☐ CPAP ☐ Crutches ☐ Prosthesis ☐ Walker ☐ Wheelchair ☐ Oxygen

☐ Other (specify):_____

Did you bring any assistive equipment to the hospital with you? ☐ No ☐ Yes

If yes please specify:_____

Do you need assistance to change positions? ☐ No ☐ Yes If yes please specify:

☐ Sitting to Stand ☐ Complete Assistance

Have you fallen in the last 2 to 4 weeks? ☐ No ☐ Yes

Sleep Apnea Screening:

Have you ever been diagnosed with obstructive sleep apnea? ☐ No ☐ Yes

If Yes what is your current treatment: ☐ Bi-Pap ☐ C-Pap Other (specify) _____

Have you had surgery for sleep apnea? ☐ No ☐ Yes

Do you snore most nights? ☐ No ☐ Yes Is your snoring loud? ☐ No ☐ Yes

Have you ever been told that you stop breathing or gasp during your sleep? ☐ No ☐ Yes

Do you occasionally doze or fall asleep during the day when you are not busy or active? ☐ No ☐ Yes

Nutrition Screening:

How is your nutritional health? ☐ Excellent ☐ Good ☐ Fair ☐ Moderate ☐ Poor

Do you have any of the following: ☐ None Apply

☐ Trouble Swallowing ☐ Large or Non-Healing Wound, Burn or Pressure Ulcer

☐ Lost 10 Pounds or More in the Last 2 Months Without Trying ☐ Tube Feeding

☐ Decreased Intake by Mouth ☐ Other (specify) _____

Do you have any dietary restrictions or preferences?_____

Elimination Screening:

Do you have any urination problems? : ☐ No ☐ Yes (specify):_____

Do you have any problems with: ☐ None ☐ Constipation ☐ Diarrhea ☐ Other: _____

When was your last bowel movement: ☐ Within the last 24 hours ☐ Today ☐ Yesterday

☐ 2-3 days ago ☐ 4-5 days ago ☐ 6 or more days ago

How often do you normally have bowel movements?

☐ Daily ☐ Every 2 days ☐ Every 3 days ☐ Every 4 or more days

Do you have: ☐ None Apply ☐ Colostomy ☐ Ileostomy ☐ Urostomy

Coping/Stress:

Have you had a recent major change/significant loss/stressor in your life? ☐ No ☐ Yes Please Specify:

☐ Birth	☐ Divorce	☐ Illness	☐ New Sibling	☐ School
☐ Death	☐ Financial	☐ Job Change	☐ Recent Move	☐ Separation
☐ Disaster	☐ Hospitalization	☐ Marriage	☐ Retirement	☐ Other (specify): _____

How do you cope with stress, loss or change? ☐ Counseling ☐ Talk with family/friend ☐ Exercising

☐ Praying ☐ Other (specify): _____

Would you like us to assist you with any needs related to your religious, spiritual or cultural practices?

☐ No ☐ Yes If yes, please specify: ☐ Devotion/ Worship ☐ Hospital Chaplain ☐ Notify Home Clergy

☐ Sacrament ☐ Sacred Writing ☐ Scripture ☐ Other (specify): _____

Safety Screening:

Are you currently in a relationship where you have been threatened or abused physically, emotionally or sexually? ☐ No ☐ Yes

Do you feel safe in your relationships at home? ☐ No ☐ Yes

Substance Use: Please Check All That Apply: ☐ None Apply (never used)

☐ Tobacco Current ☐ Tobacco Past Use ☐ Caffeine Current Use ☐ Alcohol Current ☐ Alcohol Past

☐ Street drug/Inhalant/Medication Use Current ☐ Street drug/Inhalant/Medication use Past

If Street Drug/Inhalant/Medication Use - Please Check All That Apply:

☐ Amphetamines	☐ Inhalants: (solvents, gasses, nitrites, aerosols)	☐ Narcotics
☐ Depressants	☐ Cocaine	☐ PCP (phencyclidine)
☐ Ecstasy	☐ Marijuana	☐ Sedatives
☐ Hallucinogens	☐ Mescaline	☐ Steroids
☐ Heroin	☐ Methamphetamine	☐ Stimulants

Duration of Street Drug/Inhalant/Medication Use (Month/Years): _____ Last time used: _____

Do you have exposure to second hand smoke: ☐ No ☐ Yes: ☐ Infrequent ☐ Frequent ☐ Other_____

Suicide Risk screening:

Are you feeling hopeless or worthless? ☐ No ☐ Yes

Are you having thoughts of taking your own life? ☐ No ☐ Yes Describe:_____

Learning Assessment (check all that apply):

Learning preferences: ☐ Listening ☐ Computer/Internet ☐ Group Instruction

☐ Individual Instruction ☐ Pictures ☐ Doing ☐ Verbal Instruction ☐ Video ☐ Written Material

Did you bring valuables with you? ☐ No ☐ Yes If yes check all that apply:

PLEASE SEND ALL VALUABLES HOME

☐ Billfold/Wallet/Purse ☐ Cane/Walker ☐ Clothing ☐ Contacts (both/Right/Left) ☐ Glasses

☐ Dentures (Both/Upper/Lower) ☐ Partial Bridge (Upper/Lower) ☐ Hearing Aid (Both/Right/Left)

☐ Wheelchair ☐ Watch/Jewelry ☐ Electronic devices ☐ Medication

☐ Other (specify): _____

Personal Information:

What anxieties, questions, fears or concerns do you have about your healthcare?

_____

_____

What information would help us give you more personalized care?

_____

_____

Would you like any limitations on visitors, TV or phone calls? ☐ No ☐ Yes

Please check all that apply: ☐ No phone calls ☐ No TV at night ☐ TV off ☐ No visitors

☐ Only immediate family may visit ☐ Only my spouse may visit ☐ Other (specify): _____