Cooperman Barnabas | RWJBarnabas | Medical Center

SBMC 924



Pre-Admission Evaluation Clinic Patient Questionnaire

			Date:	
Patient Name:		Date of Birth:		
Cell Phone #:		Height:	Weight:	
Home Phone #:				
Procedure:		Date of Procedure:	Date of Procedure:	
Surgeon:				
Phone #:	Fax #:			
PCP (Primary Care	e):	Do you have an appt for medical clearance?		
Phone #:	Fax #:	OYes, when?	O_{No}	
			_	
Do you see a medica	al specialist?	OYes, complete below.	O_{No}	
Cardiologist (Heart	Doctor): Name	Do you have an appt for cardiac clearance?		
Phone #:	Fax #:	OYes, when?	\circ_{N_0}	
Pulmonologist (Lun	g Doctor): Name			
Phone #:				
Other Specialist: Na	ame			
Phone #:				
Other Specialist: Na	ame			
Phone #:				
			_	

Would you <i>ACCEPT</i> a blood transfusion to save your life?	OYes	○No why? ○Religious ○Personal
Have you ever had a blood transfusion?	OYes, when?	$\circ_{ m No}$
Have you been pregnant during the previous 3 months?	OYes	ONo O N/A
Do you have Autologous (your own) or Directed Units of Blood (from family or friend) available for this procedure?	OYes	ONo
Do you take Blood Thinners (Brillinta, Coumadin, Eliquis, Plavix, Pradaxa, etc.)?	OYes	ONo
Do you take Aspirin or NSAIDs/Anti-Inflammatories (Advil, Aleve, Ibuprofen, Motrin, Naproxen, etc.) regularly?	OYes	ONo

Section: History & Physical EHR: Miscellaneous

Cooperman Barnabas | RWJBarnabas | Medical Center |

SBMC 924



Pre-Admission Evaluation Clinic Patient Questionnaire

List all PRESCRIPTION MEDICATIONS you take.		List all OVER THE COUNTER MEDICATIONS		
Include dose and frequency.		and/or VITAMINS/HERBAL SUPPLEMENTS		
		you take. Include dose and frequency.		
☐ NONE		☐ NONE		
List all ALLERGIES to	Reaction	List all ALLERGIES to	Reaction	
medications/food/latex/contrast/dye		medications/food/latex/contrast/dye		
NONE				
	l			
List all SURGERIES/PROCEDURES	Date	List all SURGERIES/PROCEDURES	Date	
NONE				
		<u> </u>		
In the last 2 weeks, what activity level can	you do the me	ost <i>without</i> chest pain or shortness of breath	?	
Check one box only.	J • • • • • • • • • • • • • • • • • • •			
☐ LIGHT INTENSITY ACTIVITIES				
> Getting dressed				
Walk around the houseWalk slow pace, level ground				
MEDIUM INTENSITY ACTIVITIE	ES			
> Climb 2 flights of stairs				
House work, cleaning, sweeping				
> Yard work, moderate effort				
Biking for pleasure, light effort				
Swimming laps leisurelyWalk moderate-fast pace, level s	round sever	al miles		
VIGOROUS INTENSITY ACTIVE		ai finies		
Climb 3 flights of stairs quickly				
Walk brisk pace, several miles				
> Biking vigorously				
> Heavy lifting				
 Run several miles Cannot perform activities due to bac 	k and/ioint n	ain or a medical condition. Please explain	•	
Use of cape crutches walker wheel	_	am or a medical condition. I least explain	•	

Section: History & Physical

EHR: Miscellaneous

Cooperman Barnabas | RWJBarnabas | Medical Center |



Pre-Admission Evaluation Clinic Patient Questionnaire

Have you or any family ever had a severe reaction to anesthesia? Ever been a "difficult intubation" or it was hard to place a breathing tube in your throat? Do you get motion sickness? History of Heart Attack Oyes, when? ONO Oronary Artery Bypass or Stent Oyes, when? ONO Valve Problems or Valve Surgery Oyes ONO Pacemaker or Defibrillator History of Congestive Heart Failure (CHF) Oyes ONO History of Congestive Heart Failure (CHF) Oyes ONO Irregular or Abnormal Heartbeat Oyes ONO Ever get chest pain, tightness, or pressure with activity (walking, running, climbing stairs, lifting something heavy)? Ever had an echo (ultrasound) of the heart or a stress test? Oyes ONO Asthma or Chronic Obstructive Pulmonary Disease (COPD) Sleep Apnea Do you use a CPAP Machine? If yes, bring your machine on day of surgery: Do you snore? Oyes ONO Do you have daytime sleepiness? Oyes ONO Do you take insulin? Oyes ONO Eyes ONO Do you check your blood sugar every day? Is your blood sugar reading over 200 in the morning? Oyes Oyes Ono Are you on Dialysis? Oyes Ono Are you on Dialysis? Oyes Ono History of Almain or Low Blood Count Oyes Oyes Ono Oyes Ono Oyes Ono History of Almain or Low Blood Count Oyes Oyes Ono Oyes Ono	Any nausea/vomit after anesthesia?	Oyes	\circ_{No}
Ever been a "difficult intubation" or it was hard to place a breathing ube in your throat? Do you get motion sickness? OYes, when? ONo History of Heart Attack Oyes, when? ONo Valve Problems or Valve Surgery Pacemaker or Defibrillator History of Congestive Heart Failure (CHF) Oyes ONo History of Congestive Heart Failure (CHF) Oyes ONo History of Congestive Heart Failure (CHF) Oyes ONo Tregular or Abnormal Heartbeat Ever get chest pain, tightness, or pressure with activity (walking, running, climbing stairs, lifting something heavy)? Ever had an echo (ultrasound) of the heart or a stress test? Oyes Ono Sleep Apnea Do you use a CPAP Machine? If yes, bring your machine on day of surgery. Do you shave daytime sleepiness? Do you take insulin? Oyes ONo Do you take insulin? Oyes ONo Sidence your blood sugar every day? Oyes Ono Kidney Disease Are you on Dialysis? History of Anemia or Low Blood Count Oyes Oyes Ono Sickle Cell Disease/Trait/Thalassemia History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Blood Clots History of Cancer? What type/location? Oyes Oyes Ono Currently on Chemotherapy or Radiation Oyes Oyes Ono Oyes Oyes Ono Oye			
History of Heart Attack OYes, when? ONO Coronary Artery Bypass or Stent OYes, when? ONO Pacemaker or Defibrillator History of Congestive Heart Failure (CHF) OYes ONO Irregular or Abnormal Heartbeat Ever get chest pain, tightness, or pressure with activity (walking, running, climbing stairs, lifting something heavy)? Ever had an echo (ultrasound) of the heart or a stress test? OYes ONO Sleep Apnea Do you use a CPAP Machine? If yes, bring your machine on day of surgery. Do you shave daytime sleepiness? OYes ONO Do you take insulin? OYes ONO Do you check your blood sugar every day? Is your blood sugar reading over 200 in the morning? OYes ONO Sickle Cell Disease/Trait/Thalassemia History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Blood Clots History of Cancer? What type/location? Currently on Chemotherapy or Radiation OYes ONO ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO ONO ONO OYes ONO ONO OYes ONO ONO ONO OYes	Ever been a "difficult intubation" or it was hard to place a breathing	OYes	ONo
Coronary Artery Bypass or Stent OYes, when? ONo Valve Problems or Valve Surgery OYes ONo Pacemaker or Defibrillator History of Congestive Heart Failure (CHF) OYes ONo High Blood Pressure OYes ONo Irregular or Abnormal Heartbeat OYes ONo Ever get chest pain, tightness, or pressure with activity (walking, running, climbing stairs, lifting something heavy)? Ever had an echo (ultrasound) of the heart or a stress test? OYes when? ONo Asthma or Chronic Obstructive Pulmonary Disease (COPD) Oyo use a CPAP Machine? If yes, bring your machine on day of surgery. Oyo you snore? Oyes ONo Do you have daytime sleepiness? OYes ONo Do you take insulin? Oyes ONo Is your blood sugar reading over 200 in the morning? OYes ONo Are you on Dialysis? OYes ONo Sickle Cell Disease/Trait/Thalassemia OYes ONo History of Anemia or Low Blood Count OYes ONo Bleed or bruise easily? OYes ONo History of Cancer? What type/location? OYes ONo Currently on Chemotherapy or Radiation OYes ONo Currently on Chemotherapy or Radiation OYes ONo OYes ONo OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO OYES	Do you get motion sickness?	Oyes	ONo
Valve Problems or Valve Surgery Pacemaker or Defibrillator Pacemaker or Defibrillator Oyes ONo History of Congestive Heart Failure (CHF) Oyes ONo High Blood Pressure Oyes ONo Irregular or Abnormal Heartbeat Oyes ONo Ever get chest pain, tightness, or pressure with activity (walking, running, climbing stairs, lifting something heavy)? Ever had an echo (ultrasound) of the heart or a stress test? Oyes when? ONo Sleep Apnea Do you use a CPAP Machine? If yes, bring your machine on day of surgery. Oyes Oyes ONo Do you have daytime sleepiness? Oyes Oyes ONo Do you check your blood sugar every day? Oyes Oyo Is your blood sugar reading over 200 in the morning? Oyes Oyes ONo Are you on Dialysis? Oyes ONo Sickle Cell Disease/Trait/Thalassemia Oyes Oyes ONo Blood Clots Oyes ONo Currently on Chemotherapy or Radiation Oyes Oyes ONo Currently on Chemotherapy or Radiation Oyes Oyes ONo	History of Heart Attack	OYes, when?	ONo
Pacemaker or Defibrillator History of Congestive Heart Failure (CHF) Oyes ONo High Blood Pressure Oyes ONo Irregular or Abnormal Heartbeat Oyes ONo Ever get chest pain, tightness, or pressure with activity (walking, running, climbing stairs, lifting something heavy)? Ever had an echo (ultrasound) of the heart or a stress test? Oyes ONo Asthma or Chronic Obstructive Pulmonary Disease (COPD) Sleep Apnea Do you use a CPAP Machine? If yes, bring your machine on day of surgery. Do you snore? Oyes ONo Do you have daytime sleepiness? Oyes ONo Do you take insulin? Oyes ONo Do you check your blood sugar every day? Oyes ONo Liver Disease Oyes ONo Sickle Cell Disease/Trait/Thalassemia Oyes ONo History of Anemia or Low Blood Count Oyes ONo Blood Clots Oyes ONo Currently on Chemotherapy or Radiation Liver Disease or History of Hepatitis Oyes ONo Currently on Chemotherapy or Radiation Liver Disease or History of Hepatitis	Coronary Artery Bypass or Stent	OYes, when?	ONo
History of Congestive Heart Failure (CHF) High Blood Pressure OYes ONo Irregular or Abnormal Heartbeat Ever get chest pain, tightness, or pressure with activity (walking, running, climbing stairs, lifting something heavy)? Ever had an echo (ultrasound) of the heart or a stress test? OYes when? ONo Asthma or Chronic Obstructive Pulmonary Disease (COPD) Sleep Apnea Do you use a CPAP Machine? If yes, bring your machine on day of surgery. Do you snore? OYes ONo Do you have daytime sleepiness? OYes ONo Do you take insulin? Oyes ONo Slep Apnea Do you check your blood sugar every day? Is your blood sugar reading over 200 in the morning? Kidney Disease Are you on Dialysis? History of Anemia or Low Blood Count Sickle Cell Disease/Trait/Thalassemia History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes ONo Currently on Chemotherapy or Radiation OYes ONo Currently on Chemotherapy or Radiation OYes ONo OYes ONo OYes ONo ONo OYes OYes OYes OYes ONO OYes OYes OYes ONO OYes OYes OYes OYes OYes OYes OYes O	Valve Problems or Valve Surgery	OYes	ONo
High Blood Pressure OYes ONo Irregular or Abnormal Heartbeat Ever get chest pain, tightness, or pressure with activity (walking, running, climbing stairs, lifting something heavy)? Ever had an echo (ultrasound) of the heart or a stress test? OYes when? ONo Asthma or Chronic Obstructive Pulmonary Disease (COPD) Sleep Apnea Do you use a CPAP Machine? If yes, bring your machine on day of surgery. Do you snore? OYes ONo Do you have daytime sleepiness? OYes ONo Do you take insulin? Oyes ONo Is your blood sugar every day? Are you on Dialysis? OYes ONo History of Anemia or Low Blood Count Oyes ONo Sickle Cell Disease/Trait/Thalassemia Oyes ONo Blood Clots Oyes ONo Currently on Chemotherapy or Radiation Liver Disease or History of Hepatitis Oyes ONo	Pacemaker or Defibrillator	OYes	ONo
Pregular or Abnormal Heartbeat	History of Congestive Heart Failure (CHF)	OYes	ONo
Ever get chest pain, tightness, or pressure with activity (walking, running, climbing stairs, lifting something heavy)? Ever had an echo (ultrasound) of the heart or a stress test? OYes when? ONO Asthma or Chronic Obstructive Pulmonary Disease (COPD) Sleep Apnea Do you use a CPAP Machine? If yes, bring your machine on day of surgery. Do you snore? OYes ONO Do you have daytime sleepiness? OYes ONO Do you take insulin? Oyes Oyou blood sugar every day? Is your blood sugar reading over 200 in the morning? Are you on Dialysis? OYes ONO History of Anemia or Low Blood Count Oyes ONO History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? Oyes ONO Currently on Chemotherapy or Radiation Liver Disease or History of Hepatitis Oyes ONO	High Blood Pressure	OYes	ONo
running, climbing stairs, lifting something heavy)? Ever had an echo (ultrasound) of the heart or a stress test? OYes when? ONo Asthma or Chronic Obstructive Pulmonary Disease (COPD) Sleep Apnea Do you use a CPAP Machine? If yes, bring your machine on day of surgery. Do you snore? OYes ONo Do you have daytime sleepiness? OYes ONo Do you take insulin? Oyes ONo Do you check your blood sugar every day? Is your blood sugar reading over 200 in the morning? OYes ONo Are you on Dialysis? OYes ONo History of Anemia or Low Blood Count OYes ONo History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes ONo History of Cancer? What type/location? Currently on Chemotherapy or Radiation Liver Disease or History of Hepatitis OYes ONo Liver Disease or History of Hepatitis OYes ONo OYes ONo OYes ONo OYes ONo OYes ONo OYes ONo OYes ONo OYes ONo OYes ONo OYes ONo OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO	Irregular or Abnormal Heartbeat	OYes	ONo
Asthma or Chronic Obstructive Pulmonary Disease (COPD) Sleep Apnea Do you use a CPAP Machine? If yes, bring your machine on day of surgery. Do you snore? OYes No Do you have daytime sleepiness? OYes No Do you take insulin? Oyes ONo Do you check your blood sugar every day? Is your blood sugar reading over 200 in the morning? OYes No Kidney Disease Are you on Dialysis? OYes No History of Anemia or Low Blood Count Sickle Cell Disease/Trait/Thalassemia OYes No History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes No Currently on Chemotherapy or Radiation Liver Disease or History of Hepatitis OYes No ONo ONo ONo OYes ONO ONO ONO OYes ONO ONO OYes ONO ONO ONO OYes ONO ONO ONO ONO ONO OYes ONO ONO ONO ONO ONO ONO OYes ONO ONO ONO ONO ONO ONO ONO O			ONo
Sleep Apnea Do you use a CPAP Machine? If yes, bring your machine on day of surgery. Do you snore? O Yes ONo Do you have daytime sleepiness? O Yes ONo Do you take insulin? O Yes ONo Do you check your blood sugar every day? Is your blood sugar reading over 200 in the morning? OYes ONo Are you on Dialysis? OYes ONo History of Anemia or Low Blood Count OYes ONo Sickle Cell Disease/Trait/Thalassemia OYes ONo History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes ONo History of Cancer? What type/location? OYes ONo Currently on Chemotherapy or Radiation OYes ONo Liver Disease or History of Hepatitis OYes ONo OYes ONo OYes ONo ONo OYes ONo OYes ONo OYes ONo OYes ONo ONo ONo OYes ONo ONo ONo ONo OYes ONo ONo ONo ONo OYes ONo ONo ONo ONo ONo ONo OYes ONo		OYes when?	ONo
Do you use a CPAP Machine? If yes, bring your machine on day of surgery. Do you snore? O Yes ONO Do you have daytime sleepiness? OYes ONO Diabetes OYes ONO Do you take insulin? O Yes ONO Do you check your blood sugar every day? Is your blood sugar reading over 200 in the morning? OYes ONO Kidney Disease OYes ONO Are you on Dialysis? OYes ONO History of Anemia or Low Blood Count OYes ONO Sickle Cell Disease/Trait/Thalassemia OYes ONO History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes ONO History of Cancer? What type/location? OYes ONO Currently on Chemotherapy or Radiation OYes ONO Currently on Chemotherapy or Radiation OYes ONO ONO Currently on Chemotherapy or Radiation OYes ONO ONO Currently on Chemotherapy of Hepatitis OYes ONO ONO	Asthma or Chronic Obstructive Pulmonary Disease (COPD)	OYes	ONo
Do you snore? Do you have daytime sleepiness? OYes ONO Diabetes OYes ONO Do you take insulin? Oyes ONO Do you check your blood sugar every day? Is your blood sugar reading over 200 in the morning? OYes ONO Kidney Disease OYes ONO Are you on Dialysis? OYes ONO History of Anemia or Low Blood Count OYes ONO Sickle Cell Disease/Trait/Thalassemia OYes ONO History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes ONO History of Cancer? What type/location? OYes ONO Currently on Chemotherapy or Radiation OYes ONO OYes ONO OYes ONO ONO OYes ONO OYes ONO ONO OYes ONO	Do you use a CPAP Machine? If yes, bring your machine on day	OYes	ONo
Diabetes OYes ONo Do you take insulin? OYes ONo Do you check your blood sugar every day? OYes ONo Is your blood sugar reading over 200 in the morning? OYes ONo Kidney Disease OYes ONo Are you on Dialysis? OYes ONo History of Anemia or Low Blood Count OYes ONo Sickle Cell Disease/Trait/Thalassemia OYes ONo History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes ONo History of Cancer? What type/location? OYes ONo Currently on Chemotherapy or Radiation OYes ONo Liver Disease or History of Hepatitis		OYes	ONo
Do you take insulin? Do you check your blood sugar every day? Is your blood sugar reading over 200 in the morning? Yes No Kidney Disease Yes No Are you on Dialysis? OYes No History of Anemia or Low Blood Count Sickle Cell Disease/Trait/Thalassemia Yes No History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes No Blood Clots Yes No Currently on Chemotherapy or Radiation OYes No OYes No ONO Liver Disease or History of Hepatitis OYes No ONO OYes ONO OYes ONO OYes ONO OYes ONO OYes ONO	Do you have daytime sleepiness?	OYes	ONo
Do you check your blood sugar every day? Is your blood sugar reading over 200 in the morning? OYes No Kidney Disease OYes No Are you on Dialysis? OYes No History of Anemia or Low Blood Count OYes No Sickle Cell Disease/Trait/Thalassemia OYes No History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes No Blood Clots OYes No Currently on Chemotherapy or Radiation OYes ONo	Diabetes	OYes	ONo
Is your blood sugar reading over 200 in the morning? No Kidney Disease OYes ONo Are you on Dialysis? OYes ONo History of Anemia or Low Blood Count OYes ONo Sickle Cell Disease/Trait/Thalassemia OYes ONo History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes ONo Blood Clots OYes ONo Currently on Chemotherapy or Radiation OYes ONo Liver Disease or History of Hepatitis OYes ONo ONo	Do you take insulin?	OYes	ONo
Kidney Disease Are you on Dialysis? OYes No History of Anemia or Low Blood Count Sickle Cell Disease/Trait/Thalassemia OYes ONo History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes ONo Blood Clots OYes ONo Currently on Chemotherapy or Radiation OYes ONo ONo ONo ONo ONo OYes ONo ONo ONo ONo ONo ONo ONo ON	Do you check your blood sugar every day?	OYes	ONo
Are you on Dialysis? History of Anemia or Low Blood Count Sickle Cell Disease/Trait/Thalassemia OYes ONo History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes ONo Blood Clots OYes ONo OYes ONo Currently on Chemotherapy or Radiation OYes ONo	Is your blood sugar reading over 200 in the morning?	OYes	ONo
History of Anemia or Low Blood Count Sickle Cell Disease/Trait/Thalassemia OYes ONo History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes ONo Blood Clots OYes ONo OYes ONo Currently on Chemotherapy or Radiation OYes OYes ONo	Kidney Disease	OYes	ONo
Sickle Cell Disease/Trait/Thalassemia OYes No History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes ONo Blood Clots OYes ONo History of Cancer? What type/location? OYes ONo Currently on Chemotherapy or Radiation OYes ONo OYes ONo OYes ONo ONo OYes ONo OYes ONo ONo OYes ONo ONo OYes ONo	Are you on Dialysis?	OYes	ONo
History of Blood Disorder (Hemophilia, Factor 5, 7 or 11 Deficiency, etc.) Bleed or bruise easily? OYes ONo Blood Clots OYes ONo History of Cancer? What type/location? Currently on Chemotherapy or Radiation OYes ONo	History of Anemia or Low Blood Count	OYes	ONo
etc.) Bleed or bruise easily? OYes ONo Blood Clots OYes ONo History of Cancer? What type/location? Currently on Chemotherapy or Radiation OYes ONo Liver Disease or History of Hepatitis OYes ONo	Sickle Cell Disease/Trait/Thalassemia	OYes	ONo
Bleed or bruise easily? Blood Clots O'Yes ONo History of Cancer? What type/location? Currently on Chemotherapy or Radiation O'Yes ONo Liver Disease or History of Hepatitis O'Yes ONo		OYes	ONo
History of Cancer? What type/location? Currently on Chemotherapy or Radiation OYes ONo Liver Disease or History of Hepatitis OYes ONo		OYes	ONo
Currently on Chemotherapy or Radiation OYes ONo Liver Disease or History of Hepatitis OYes ONo	Blood Clots	OYes	ONo
Liver Disease or History of Hepatitis OYes ONo	History of Cancer? What type/location?	OYes	ONo
	Currently on Chemotherapy or Radiation	OYes	ONo
Any Ulcers, Reflux, or Heartburn?	Liver Disease or History of Hepatitis	OYes	ONo
	Any Ulcers, Reflux, or Heartburn?	OYes	ONo

Page 3 of 4 Section: History & Physical

Cooperman Barnabas | RWJBarnabas | Medical Center |



Pre-Admission Evaluation Clinic Patient Questionnaire

History of Stroke (CVA) or Mini Stroke (TIA)	OYes	\circ_{No}
Ever fainted or "blacked-out" in the last year	OYes	ONo
Seizures/Epilepsy	OYes	ONo
Depression or Anxiety requiring treatment	OYes	ONo
HIV/AIDS	OYes	ONo
History of COVID Infection?	OYes, when?	ONo
Were you hospitalized?	OYes	ONo
Do you currently smoke or vape? If yes, how many PPD? How often?	OYes	ONo
Do you drink alcohol? If yes, how many drinks? How often?	OYes	ONo
Do you use recreational drug (street drugs)? If yes, what kind? How often?	OYes	ONo
Any unplanned weight loss in the last 6 months? If yes, how much?	OYes	ONo
Have you been eating less than 50% of your normal diet compared to last week?	OYes	ONo
When was your last menstrual period?		O _N /A
Are you breastfeeding?	OYes	ONo ON/A
Have you received the COVID-19 Vaccination(s)/Booster(s)? If yes, how many? When?*Please give copy of your card to staff.	OYes	ONo
Have you been in close contact (shared living space or in a close physical contact) with a person presumed positive or has tested positive for COVID-19 Infection in the last 14 days?	OYes	ONo
Do you currently have: Fever	OYes	ONo
Do you have any other medical conditions you would like to mention?	OYes	ONo

SBMC 924 Section: History & Physical EHR: Miscellaneous