Date: _____Date of Birth:_____ HT*_____(inches) WT* _____(lbs.) **required*

Patient Name:_____Preferred Name: _____

Best Contact Numbers: _____Form Completed By:_____

Primary Doctor: (name/number) _____Date Last Seen: _____

Cardiologist: (name/number)_____Date Last Seen: _____

Medical History (check all that apply and provide additional comments below): ☐ None

	Heart/Cardiac *(check all that apply)*
	High blood pressure
	Chest pain/Angina Date:
	Heart attack Date:
	Heart surgery Date:
	Angioplasty or Stent Date:
	Pacemaker/AICD Date:
	Congestive heart failure
	Heart valve problem
	Abnormal rhythm (i.e. atrial fib)
	Lungs/Pulmonary *(check all that apply)*
	Asthma
	COPD /Emphysema
	Sleep apnea/CPAP
	Home oxygen
	Shortness of breath after climbing 2 flights/stairs or walking 4 blocks
	Diabetes/Renal *(check all that apply)*
	Diabetes (take pills)
	Diabetes (insulin or insulin pump)
	Kidney failure/Dialysis
	Kidney Transplant Date:

	Heart/Cardiac Tests *other than ECG*
	Stress Test Date:
	Cardiac Echo Date:
	Neurologic *(check all that apply)*
	Brain surgery/Injury
	Dementia/Alzheimer's disease
	Stroke Date:
	Prolonged numbness or paralysis
	Epilepsy/Seizures
	Fainting/Loss of consciousness
	Mental health issues
	Anesthesia Related *(check all that apply)*
	Self and/or blood relatives had problems with previous anesthetics
	Difficulty moving head, neck
	Difficulty opening mouth
	Loose or chipped teeth
	Dentures/Crowns/Caps/Veneers
	Contact Lenses/Hearing Aids
	Blood Disorders *(check all that apply)*
	Easy bruising/bleeding
	Blood clot problem
	Anemia
	Blood diseases

	Exercise/Activity *(check all that apply)*
	What type:
	How long (hrs./min.):
	How often:
	Additional History *(check all that apply)*
	Thyroid disease
	Cancer, Chemotherapy/Radiation Date:
	MRSA/VRE
	Latex allergy
	Chronic pain
	Prednisone/steroids in last 6 mos.
	Hospitalized in last 30 days
	Drug/Alcohol Addiction/ Withdrawal
	Smoker # Packs/Day:_____ Year Start: Year Quit:
	Gastrointestinal *(check all that apply)*
	Hiatal Hernia
	Heartburn/Acid reflux
	Hepatitis/Cirrhosis
	Females Only *(check all that apply)*
	Last menstrual period Date:
	Currently/Possibly pregnant
	Currently Breastfeeding

Other/Comments: _____

_____

_____

_____

_____

Prior Surgeries with Dates: _____

_____

_____

_____

_____

SHARP®

PRE-ANESTHESIA SCREENING

FOR OFFICE USE ONLY: PLEASE CIRCLE TESTING PLAN

Labs to be done at: n/a SRS Quest Labcorp PAES
Other_____
On _____ (Date)
EKG/other cardiac testing to be done at: n/a SRS SDCC PAES
Other test_____On _____ (Date)

PATIENT IDENTIFICATION

Name:_____ Birthdate:_____

SHARP

PATIENT HOME MEDICATIONS

(Not a Physician's Order Form)

Date _____ / _____ /_____ Time _____ ☐ Patient Takes NO Medications ☐ Home Medication Information Unavailable

MEDICATION ALLERGIES / INTOLERANCES	DESCRIBE REACTION

List all prescription (including insulin, eye drops, inhalers, heart, blood pressure, blood thinners) and non-prescription medications such as vitamins, aspirin and herbs.

CURRENT HOME MEDICATION	DOSE	HOW TAKEN	HOW OFTEN	LAST DOSE TAKEN	COMMENTS	DISCHARGE STATUS ** *(circle one)*	
						TAKE	STOP
						TAKE	STOP
						TAKE	STOP
						TAKE	STOP
						TAKE	STOP
						TAKE	STOP
						TAKE	STOP
						TAKE	STOP
						TAKE	STOP
						TAKE	STOP
						TAKE	STOP
						TAKE	STOP

****Take** = No changes from previous direction **Stop** = Stop Drug or Dose

Admission Medication Review:

Reviewed with Patient / Family: RN Signature _____ Date _____ Time _____

Updated: RN Signature _____ Date _____ Time _____

Updated: RN Signature _____ Date _____ Time _____

Discharge Medication Reconciliation Addressed

☐ There are NO changes to the previous medication.

_____Date_____Time_____
Physician Signature
OR
_____Date_____Time_____

☐ VO/TO Read Back RN Signature or ☐ RN Completion

☐ I have given the following discharge prescription(s) to patient

_____

_____

PATIENT IDENTIFICATION