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 If yes, date: ____/____/________	**If previous patient, has your name changed since last visit?** ☐ Yes ☐No *If yes, what was your previous name?* __________________________
Primary or native language ☐English ☐Spanish ☐Chinese-Mandarin ☐Chinese-Cantonese ☐Russian ☐Sign Language ☐ other:____________ **Preferred language to discuss health information** ☐English ☐Spanish ☐Chinese-Mandarin ☐Chinese-Cantonese ☐Russian ☐Sign Language ☐ other:____________	**Will you require a language interpreter?** ☐Yes ☐ No

Date of Birth (MM/DD/YYYY) ______/_______/____________ Age:__________	Gender: ☐Male ☐ Female	Height:______ feet ____inches Weight:__________lbs.

Name of Person (Escort) who will take you home after surgery: ______________________________	**Escort Contact Phone #:** (_______) __________ – ______________

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: ______________ ☐Cigarette smoker ☐Every day ☐Some days Cigarettes per day: _____ ***OR*** Packs per day:__________ Cigar/Pipe Smoker: ☐Yes ☐ Light ☐Heavy Years Tobacco use (any type): ____________

ANESTHESIA HISTORY	
Do you have a history of problems with anesthesia? ☐No ☐Yes	**Has a family member had a history of problems with anesthesia?** ☐No ☐Yes

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MEDICAL HISTORY

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

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Skin/ Integumentary Problems	☐ **No**	☐Eczema ☐Psoriasis ☐Rash ☐Shingles ☐ Herpes ☐Pressure Ulcers ☐ Wounds/Recent surgical Incision ☐Other:______ ☐**Body Piercings:**______ **NOTE: ALL Piercing jewelry MUST be removed before arriving for surgery** ☐**AV Fistula** ☐**Mediport** ☐**PICC line**
Infectious Disease Problems	☐ **No**	☐AIDS/HIV ☐MRSA ☐ Antibiotic resistant infection (VRE) ☐ Other: ______
Cancer: *If* not previously *listed*	☐ **No**	Site: ______ 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

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:**______________