# PREOPERATIVE NURSING ASSESSMENT SHEET

**PAGER#** _____
**FAMILY/DRIVER/ESCORT NAME:** _____
**WAITING/CALL** _____/_____ **MIN. AWAY** _____

Date: _____ Time: _____ Planned Aethesia: _____ Pre-op Diagnosis: _____

Planned Procedure(s): _____

Age:_____ Ht.: _____ Ft: ____ in. Wt. stated: _____ actual: _____ BMI: _____

NPO Since: _____ Temp: _____ Pulse: _____ Resp. _____ B/P _____/_____ SPAO2 _____% Pain 0-10_____

☐ NKDA or Allergies Drug/Food/Environmental(with Reaction):

| Medical History | Y / N | |
|---|---|---|
| Cardiovascular | Y / N | HTN/ CHF/ Artificial Heart Valve/ Blood Clots/ Irregular Heart Beat/ High Cholesterol/ Chest Pain/ Heart Mock/ MI/CABG<br>Pacemaker/Defibrillator/ Date Placed: _____ Last Interrogation: _____<br>Other/Explanation: _____ |
| Pulmonary | Y / N | Emphysema/COPD/Asthma/ Tuberculosis/Sleep Apnea/Snoring /CPAP/BiPAP/ Cough or cold<br>Other/Explanation: _____ |
| Endocrine | Y / N | Hypo/Hyperthyroidism/ Chronic Steroid Use / Diabetes -Type I (IDDM) or Type II (NIDDM)<br>Other/Explanation: _____ |
| Musculoskeletal/ Neurological | Y / N | Parkinson's/Multiple Sclerosis/ Depression/ Anxiety/ Impaired- Hearing/Speech/ Stroke/ TIA/ Seizure<br>Weakness/Numbness Location: _____ Back, Neck, or Jaw Pain/ Arthritis _____<br>Plates/Pins/Screws/Metal or Hardware location: _____<br>Other/Explanation: _____ |
| Gastrointestinal | Y / N | Recent Nausea Vomiting or Diarrhea/ Frequent Heartburn/ GERD/Rellux/Hiatal Hernia/ History of Motion Sickness/Cirrhosis/<br>Jaundice or Hepatitis Type: _____ Other/Explanation: _____ |
| Hema/Oncology | Y / N | Abnormal Bleeding / Anemia / Sickle Cell Disease (or trait) / Leukemia / HIV / AIDS<br>Cancer/Type: _____ Last Radiation: _____ Last Chemo: _____<br>Blood Thinners (Aspirin, Aspirin products, Coumadin, Plavix, Other_____) last dose: _____<br>Other/Explanation: _____ |
| Habits | Y / N | Smokes_____ PPD x's_____ years Recreational Drug Use Type: _____ Last Used: _____<br>Alcohol _____ Drinks per _____ (How many drinks/How often used)<br>Other/Explanation: _____ |
| GU/GYN | Y / N | LMP: _____ Hysterectomy/Tubal ligation/ Endometrial Ablation<br>Stress Incontinence/Kidney Stones/ CRF/Dialysis/Enlarged Prostate Other/Explanation: _____ |
| Integumentary | Y / N | Cuts/Scrapes/Scratches/Bruises/Psoriasis/ Other Skin Lesions-location(s): _____<br>Hx of MRSA Other/Explanation: _____ |
| Anesthesia History | Y / N | Post Op Nausea or Vomiting/ Malignant Hyperthermia/ Difficult Intubation Other/Explanation: _____ |
| Surgical History Previous Surgeries w/dates (if dates known) | Y / N | |
| The Following Pre-operative Instructions Given, Patient Verbalizes Understanding | | Arrive on _____ (Date) @ _____ (Time) _____<br>☐ Nothing to eat or drink after midnight (no smoking, water, candy, etc.)<br>☐ Do not take Lisinopril, ace inhibitors, or insulin day of surgery ☐ Fleets Enema/Antibiotic prior to Prostate Bx<br>☐ Do not take Coumadin, Plavix, Aspirin or Aspirin based products unless otherwise instructed by Cardiologist or Primary Care AND your surgeon is aware.<br>☐ Instructed may take the following medications with a small sip of water morning of procedure: _____<br>_____ ☐ Wear loose comfortable clothing ☐ Bring rescue inhaler ☐ Bring CPAP, if applicable<br>☐ Must have a designated driver, responsible adult to sign discharge paperwork, and be with you for 24 hours after procedure, if you receive Anesthesia.<br>☐ Patient given address, directions, and phone number of facility |

Information Obtained by: _____ Signature: _____ Date/Time. _____

Information Verified DOS by Admitting RN: _____ Signature: _____ Date/Time: _____

Information Verified DOS by Anesthesia:_____ Signature: _____ Date/Time' _____

# HOME MEDICATION RECONCILIATION SHEET

❑ NKDA or Allergies Drug/Food/Environmental (with Reaction):

## Current Medications

List all prescription and all over-the-counter medications. Information obtained from ❑ Patient ❑ Family ❑ Written List ❑ Prescription Bottle

❑ No routine medications taken at home

| Resume | Medication | Dose | Route | Frequency | Reason | Last Dose Date | Last Dose Time |
|---|---|---|---|---|---|---|---|
| Y / N | | | | | | | |
| Y / N | | | | | | | |
| Y / N | | | | | | | |
| Y / N | | | | | | | |
| Y / N | | | | | | | |
| Y / N | | | | | | | |
| Y / N | | | | | | | |
| Y / N | | | | | | | |
| Y / N | | | | | | | |
| Y / N | | | | | | | |
| Y / N | | | | | | | |
| Y / N | | | | | | | |
| Y / N | | | | | | | |

Signature of nurse verifying date of surgery _____ Date _____/ _____ /_____ Time _____
Signature of patient verifying list is complete and accurate_____ Date _____/ _____ /_____ Time _____

### New Medications

| Medication | Dose | Route | Frequency | Reason | Next Dose Due |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

PATIENT STICKER

❑ Hold _____ (name of medication) until _____ (date to resume)

Physician signature _____ Date _____/_____/_____ Time _____

Nurses signature _____ Date _____/_____/_____ Time _____

By signing this I verify I understand instructions regarding the above medication

Signature of responsible adult _____ Date _____/_____/_____ Time _____