FRANKLIN GENERAL HOSPITAL
An Affiliate of MERCYONE

SURGERY DEPARTMENT

1720 Central Ave East, Hampton IA 50441
Phone: 641-456-5032 Fax: 641-456-5089

Patient Health Information Form

Complete and return this form **at least 5 days prior** to your procedure

Patient Information:

Name:	**Date of Birth**:	☐ Male ☐ Female
Telephone Home: Work: Cell:		
E-mail address:		

Planned Procedure:

Please mark the procedure you will be having: ☐EGD ☐Colonoscopy ☐ Flex Sigmoid ☐Surgical procedure: _____	**Date of Procedure:** *(if scheduled)*

General Information:

Primary Language: ☐English ☐ Spanish ☐ Other:
Do you need an interpreter? ☐ yes ☐ no

You will need transportation after your procedure.

Do you have transportation arranged for the procedure? ☐ yes ☐ no

If yes, please list Driver here:

Name: **Phone Number:**

Medical Information:

Primary Care Physician:		Date of Last exam:
Do you use any of the following: ☐ glasses ☐ hearing aids ☐ dentures		
Height:	Weight:	Pregnant? ☐ yes ☐ no Date of Last menstrual Period:
Do you have a Medical Power of Attorney (MPA)? ☐ yes ☐ no Do you have a living will? ☐ yes ☐ no **Contact information for MPA:** Name: Phone:		

Medications ☐Check here if you are not currently taking any medications.

(List all medications including vitamins, herbs, over-the-counter medications, inhalers or attach current list)

Name of medication (generic or name brand)	**Dose** (mg, oz, units)	**How do you take it?** (by mouth, injection, eyes)	**How often taken** (Daily, 2xday, weekly)

Allergies ☐ **No known medication allergies** *(please list all medication, food and environmental allergies)*

Allergy	Reaction

Medical History (*Please check if you have or had any of the following medical conditions.)*

☐ Asthma
☐ Emphysema
☐COPD (*Chronic obstructive pulmonary disease*)
☐Sleep apnea or CPAP/BiPAP use
☐Oxygen Usage
☐Congestive heart failure
☐ Heart attack
☐ Stroke
☐ Stomach ulcers
☐ Small bowel obstruction
☐ GERD *(heartburn)*
☐ Diverticulosis
☐ Difficulty swallowing
☐ Cancer, type:
☐ Liver disease
☐ Kidney disease
☐ High cholesterol
☐ High blood pressure
☐ Seizures/Epilepsy
☐ Gallbladder disease

☐ Other: _____

Surgical History

	Year		Year				Year
Colonoscopy		Coronary bypass		Knee replacement		Pacemaker	
Gallbladder		Coronary stent		Heart surgery		Prostate surgery	
Appendectomy		EGD (upper scope) esophagogastroduodenoscopy		Hernia surgery		Sigmoidoscopy	
Head		Cataract removal		Hip replacement		Sinus surgery	
Neck		Back		Spine		Tonsillectomy	
Breast surgery		Defibrillator		Hysterectomy		Tubal ligation	
Other:							

Social History

Do you smoke cigarettes, cigars, pipes? ☐ current smoker ☐ past smoker ☐ never smoked
Have you smoked cigarettes anytime during the last 12 months? ☐ Yes ☐ No
Any History of Electronic Cigarette/Vaping? ☐ Current ☐ Past ☐ Never

Do you chew tobacco? ☐ current ☐ past ☐ never

Do you drink alcohol? ☐ current drinker ☐ past drinker ☐ never drink
If yes, do you drink: ☐ daily ☐ weekly ☐ monthly ☐ yearly
How many drinks do you have in one sitting? _____
Ever been treated for alcoholism? ☐ Yes ☐ No

Substance Abuse? ☐ Never ☐Past ☐Current

Anesthesia Screening and History

Check all types of anesthesia you have had in the past.

☐None
☐General Anesthesia
☐Spinal Anesthesia
☐Epidural Anesthesia
☐Moderate Sedation
☐Unknown

Please check all anesthesia reactions you may have had for each type of anesthesia.

General Anesthesia reactions

☐None ☐ Awareness ☐ Cardiac Arrest
☐Difficult intubation ☐ Excessive post-op nausea ☐ Hypertension
☐**Malignant hyperthermia** ☐ Vomiting ☐ Unknown reaction

Other:_____

Spinal Anesthesia **Epidural Anesthesia** **Moderate Sedation**
☐None ☐ Nausea ☐ Vomiting

General Anesthesia Assessment
Do any of the following apply to you?
☐Loud snoring ☐ Frequent Daytime Fatigue ☐ Observed apnea during sleep

Dental/Oral Problems

☐ Bridges ☐Caps/Crowns ☐Chipped teeth ☐Loose teeth ☐Orthodontic appliance

SAVE THIS PAGE FOR YOUR REFERENCE

Pre-operative instructions:
FGH surgical department will contact you with a pre-operative phone call prior to your scheduled procedure.

Phone call will include:

- Registration time, medications to take prior to procedure, pre-op instructions, bowel prep instructions (if applicable), and we will answer any questions you may have.

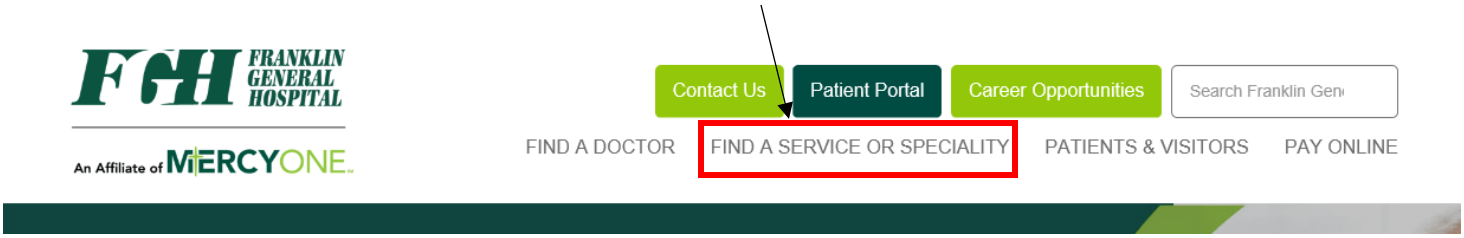
- Items on this form will be reviewed during the pre-operative phone call. If this form is not received prior to the phone call, it will be completed over the phone. Please allow 15-20 minutes to complete over the phone.

Do you have any questions?

- Feel free to call us with any questions you may have at 641-456-5032. We are open Monday-Friday from 7AM-3PM.

Questions about your prep?

- Visit our hospital website at franklingeneral.com
- Choose "Find a Service or Specialty" from the top menu



- Choose "Outpatient and Surgical Services" from the menu of services on the left
- On the next page, select any of the following options on the left to learn more about your surgery prep.
- Colonoscopy prep instructions can be found here, or on the "preparing for surgery" page. *(Golytely, Suprep, etc.)*

PREPARING FOR SURGERY (WEBPAGE)
You will receive a call the day prior to your surgery regarding arrival time and pre-surgery instructions. If you have not received a call from the surgical

DAY OF SURGERY (WEBPAGE)
On the day of surgery, please report to 24/7 Registration desk at the Emergency entrance. Bathe or shower as usual the day of your surgery, removing all

AFTER SURGERY (WEBPAGE)
Q. Do I need someone to be with me the first night home? A. We do recommend that you have someone stay with you on your first night home. If you cannot