# OUTPATIENT HISTORY

Shaded Areas are for Staff use only

VERIFY PATIENT ID (2 required) ❑ NAME ❑ DOB ❑ OTHER________________

| DATE___/___/_____<br>TIME: ___/___/_____ | AGE OF PATIENT<br>Age ____________ | ACTUAL HEIGHT & WEIGHT<br>Height________ Wt._________ ❑ N/A | PREGNANT<br>❑Yes ❑No | BREASTFEEDING<br>❑ Yes ❑ No |
|---|---|---|---|---|

**PATIENT/FAMILY TO COMPLETE THE FOLLOWING:**

**I. Health Problems**: **Check and / or circle if you have or had any of the following?**

| | Yes | | Yes | | Yes | | Yes |
|---|---|---|---|---|---|---|---|
| Diabetes | | High / Low Blood Pressure | | Difficulty Swallowing | | Depression / Anxiety | |
| Heart Problems/ Disease | | Pacemaker / AICD | | Seizures | | COPD/Pneumonia | |
| Asthma / Trouble Breathing | | Surgical Clips | | Difficulty Urinating | | *Unsteady Walk / Falls | |
| Thyroid Problems | | Hepatitis / Liver Disease | | Arthritis | | Chest Pain | |
| Kidney Disease/ Dialysis | | Cancer____________(Type) | | *Stroke | | Headaches/ *Dizziness | |
| Surgery | | Chemotherapy | | *TIA | | Migraine | |

**II. PAIN:** ❑No ❑Yes Circle number that describes the intensity of your pain: (1-3 mild, 4-7 mod, 8-10 severe) 1 2 3 4 5 6 7 8 9 10

Type / Quality: ________________ Location: ________________ Patient Stated Pain Goal (age appropriate scale 0-10)______

What, if anything, makes your pain worse?________________________________________________

What, if anything, makes your pain better?________________________________________________

**III. Previous Surgeries:** ________________________________________________

________________________________________________________________

________________________________________________________________

**IV. Medications:** List all prescription and over-the-counter medications, herbal remedies, and/or supplements.

***PLEASE PRINT CLEARLY***

| Name of Medication | Dose | How Taken | How Often | Time Last Dose | Name of Medication | Dose | How Taken | How Often | Time Last Dose |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

**V. Medication Allergies**

Have you had a true allergic reaction – such as 1. Red rash 2. Hives 3. Swelling 4. Shortness of breath 5. Wheezing – to any drugs? ❑No ❑Yes If Yes, state name of medication, and indicate type of reaction to each: ____________________________________

________________________________________________

________________________________________________

**VI. Medication Side Effects:**

Have you had a significant side effect – such as 1. Vomiting 2. Upset stomach 3. Diarrhea 4. Constipation 5. Headache - to any drugs? ❑No ❑Yes If Yes, state name of medication, and indicate type of reaction to each: ____________________________

________________________________________________

________________________________________________

**VII. ALLERGIES:** Have you had an allergic reaction to food or other substance? ❑No ❑Yes If yes, list item and reaction:

________________________________________________________________

**VIII. Latex Allergy:**

When exposed to latex or rubber, (including rubber gloves used by you or your doctor, balloons, condoms) do you suffer runny nose, watery eyes, wheezing, or rash? ❑No ❑Yes, explain:________________________________________________

Do you have spina bifida or repeated catheterizations from congenital defects? ❑No ❑Yes, explain: ________________________________

Do you have **breathing** reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados, or cherries)? ❑No ❑Yes, explain________________________________________________

**IF YES HAS BEEN CHECKED OFF ONE OR MORE TIMES, USE LATEX PRECAUTIONS**

❑ Latex precautions indicated and initiated ❑ Latex allergy education material provided to patient

❑ **No Fall Risk** *❑ Fall Prevention Plan implemented

❑ **No Evidence of Abuse/Neglect:** (Do you feel safe at home?) ❑ If Evidence of Abuse/Neglect, Social Services contacted.

❑ **No Special cultural needs identified** (i.e. religious or dietary practices). If Yes, identify________________________________

**Preferred Method of Learning:** ❑ Visual ❑ Auditory ❑ Written **Preferred Language**__________________________

**Barriers to Learning:** (What keeps you from learning?) ❑ Visual ❑ Auditory

If Yes, identify:________________________________________________________________

Patient/Significant Other verbalizes understanding of education/instructions. If no, provide plan for re-education in notes. ❑ See notes.

Reviewed by __ ________________________________/Print Name________________________ Date:___________ Time:___________

**OUTPATIENT HISTORY**

**PATIENT IDENTIFICATION**

CI (12/11)

TORRANCE MEMORIAL MEDICAL CENTER