

****PLEASE EITHER BRING THIS FORM WITH YOU WHEN YOU COME FOR YOUR PRE-ADMISSION TESTING OR, TO EXPEDITE THE PROCESS, FAX TO: 631-654-7786****

Brookhaven Memorial Hospital Medical Center

PRE-ADMISSION TESTING WORKSHEET

Anesthesia: Have you had anesthesia in the past? No Yes

If "yes", did you have any serious complications? No Yes If "yes", describe: _____

Body Piercing: site(s) _____ Advised to remove before surgery **Tattoos:** site(s) _____

Family History:

Is your father?: living deceased age: _____ cause of death: _____

Is your mother?: living deceased age: _____ cause of death: _____

Brothers: How many living: _____ deceased: _____ cause of death: _____

Sisters: How many living: _____ deceased: _____ cause of death: _____

Is there a family history of?:

(grandfather, father, sister, etc)

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Medical Condition	Which relative?	Medical Condition	Which relative?
Diabetes		Tuberculosis (TB)	
Heart problems		Emphysema	
Cancer		Kidney problems	
High blood pressure		Other	

EXISTING PROBLEMS

Do you have to wear: (please circle): contact lenses intraocular lenses glasses hearing aides
Dentures dental crowns dental bridges prosthesis of any type

Do you have? (If so, please describe):

Any disability or handicap? _____

Any urinary problems? _____

Any bowel problems? _____

Any recent weight change? _____

Any diet restriction? If so, what: _____

Do you use tobacco, alcohol or drugs: If yes, indicate type and frequency, how much and how long? _____

If you no longer use these substances, please indicate when you stopped: _____

For women:

What was the date of your last period? _____

How many pregnancies have you had?: _____ Miscarriages: _____ Abortions: _____ Deliveries: _____

What was the date of your last PAP Smear? _____ last Mammogram? _____

Do you use birth control? Yes No If yes, what type? _____

Occupation: If retired, please indicate what you did: _____

Will you return to your present address after you leave the hospital? Yes No

Do you live with someone, who can assist with your care, if necessary, after you leave the hospital? Yes No

If "yes", please indicate who? _____

****PLEASE TURN PAGE OVER AND COMPLETE REVERSE SIDE****