Patient Name:_____ Primary Doctor (PCP):_____ Surgeon:_____

Cardiologist:_____ Nephrologist:_____ Other Doctors:_____

Information obtained from: ❑ Patient ❑ Family_____ Other_____ Chief Complaint:_____

Information via ❑ phone ❑ interview Primary Language:_____ Ht_____ Stated Wt_____lbs Actual Wt_____lbs____kg

Medical History: (check all that apply)

❑ Cancer Type_____
❑ Node Dissection:_____
❑ Anemia ❑ Stimulator
❑ Arthritis ❑ Artificial Joint_____
❑ Muscle Disease:_____
❑ Diabetes: NIDDM IDDM
❑ Eye Disease ❑ Eye Implants
❑ Epilepsy / Seizures
❑ Pain ❑ Acute ❑ Chronic
❑ Heart Disease:_____
❑ Mitral Valve Prolapse/Heart Murmur
❑ Low/High Blood Pressure ❑ Stroke
❑ Pacemaker ❑ Stents ❑ Defibrillator

❑ Lung Disease
❑ Asthma ❑ COPD ❑ Emphysema
❑ Sleep Apnea ❑ BiPap/CPap
❑ Oxygen _____liter per min.
❑ Thyroid Disease
❑ Liver Disease / Hepatitis
❑ Bowel Disease (Type):_____
❑ Prostate Disease
❑ Kidney Disease: Schedule:_____
Dialysis Center: _____
❑ Last menstrual cycle:_____ ❑ Pregnant
❑ Street drugs
❑ Alcohol Type:_____Amt. / Day:_____
❑ Tobacco Type:_____Amt. / Day:_____

❑ Tattoos ❑ Body piercing
❑ Anesthesia or sedation reaction:_____
❑ Hx of Malignant Hyperthermia_____
❑ Blood Transfusion Reaction: _____

Other Problems : _____

❑ Family History of: ❑ Cancer ❑ Diabetes
❑ Heart Disease ❑ Malignant Hyperthermia

❑ No medical problems identified

TB Assessment Screen (Check all that apply) ☐ None ☐ Cough for 2 wks or longer ☐ TB exposure ☐ *Positive TB skin test
☐ *Night Sweats ☐ *Bloody Sputum ☐ Weight Loss ☐ Fever ☐ Loss of appetite ☐ Fatigue

Vaccines: Flu shot? ☐ No ☐ Yes Mo/Yr_____/____ Tetanus ☐ No ☐ Yes Mo/Yr_____/_____
Pneumonia vaccine ☐ No ☐ Yes Mo/Yr_____/____ Diptheria ☐ No ☐ Yes Mo/Yr_____/_____

Thrombosis Risk Factor Assessment: (Check only for all that apply for patients above the age of 18 years old.)

Each Risk Factor Represents 1 point
❑ Age 41-59 years
❑ Minor Surgery Planned (< 1 month)
❑ Varicose Veins
❑ History of Inflammatory Bowel Disease
❑ Swollen Legs (Current)
❑ Obesity
❑ Acute Myocardial Infarction
❑ Congestive Heart Failure (CHF)
❑ Sepsis
❑ Abnormal Pulmonary Function (COPD)
❑ Birth Control Pills or Hormone Replacements
❑ Pregnancy or Postpartum for <1 month
❑ History of Unexplained Stillborn Infant
❑ Recurrent Spontaneous Abortion (≥3)
❑ Premature Birth with Toxemia, or Growth-Restricted Infant
❑ **SCORE** _____

Each Risk Factor Represents 2 Points
❑ Age 60-74 years
❑ Arthroscopic Surgery
❑ Cancer (Present or Previous)
❑ Planned Major Surgery
❑ Planned Laparoscopic Surgery
❑ Patient Confined to Bed for >72 hours
❑ Immobilizing Plaster Cast for <1 month
❑ Central Venous Access
❑ **SCORE** _____

Each Risk Factor Represents 5 Points
❑ Elective Major Lower Extremity Arthroplasty
❑ Hip, Pelvis, or Leg fracture (<1 month)
❑ Hip or Knee Replacement (<1 month)
❑ Recent Stroke (<1 month)
❑ Multiple Trauma (<1 month)
❑ Paralysis (<1 month)
❑ **SCORE** _____

Each Risk Factor Represents 3 Points
❑ Age ≥ 75 years
❑ History of DVT/PE
❑ Family History of Thrombosis
❑ Positive Factor V Leiden
❑ Elevated Serum Homocysteine
❑ History of Lupus
❑ Elevated Anticardiolipin Antibodies
❑ Heparin-Induced Thrombocytopenia, Other Congenital or Acquired Thrombophillia
❑ If yes: Type_____
❑ **SCORE** _____

Total Risk Factor Score _____

See Medication Reconciliation Form for Patient Medications **Pharmacy Name:**_____

ALLERGY TO:	TYPE OF REACTION	ALLERGY TO:	TYPE OF REACTION	**List all surgeries, endoscopies, angiograms or hospital stays**
Latex Allergy ❑ Yes ❑ No				

I verify the Health History provided are true / correct. This form has been reviewed with me by a licensed nurse.

Patient / Responsible party:_____ Date:_____ Time:_____

Nurse:_____Initials_____ Date:_____ Time:_____

Nurse:_____Initials_____ Date:_____ Time:_____

Scanned to pharmacy by: _____Date:_____ Time:_____

COVENANT HEALTH SYSTEM
Lubbock, Texas

AMBULATORY PATIENT HEALTH HISTORY FORM

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