SHASTA CRITICAL CARE
Specialists

NEW PATIENT ADMISSION ASSESSMENT

Patient name:_____ Date:_____
Who is your family doctor:_____

Are you allergic to any medications and what type of reaction do you have:
_____
_____
_____

PAST MEDICAL HISTORY

YES	NO	
___	____	Heart Disease (heart attacks, heart failure, rheumatic fever, etc.)
___	____	Lung Disease (asthma, emphysema, bronchitis, pneumonia, etc.)
___	____	Gastrointestinal (ulcers, cancer, hepatitis, etc.)
___	____	Endocrine (diabetes, thyroid disease, etc.)
___	____	Blood disease (anemia, clotting disorders, etc.)
___	____	Kidney and or bladder (chronic bladder or kidney infections, etc.)
___	____	Cancer-please describe_____

Other health problems not listed above:_____
_____

OPERATIONS: (list operation and year of surgery)
_____
_____

IMMUNIZATIONS: (when was your last)
Tetanus shot_____ Pneumonia shot_____
TB skin test_____ Flu shot_____

CURRENT MEDICATIONS

Name of drug	Strength	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently using Oxygen? Yes No If yes, what is the name of your oxygen company?
_____

HOSPITAL PREFERENCE_____

PHARMACY PREFERENCE _____