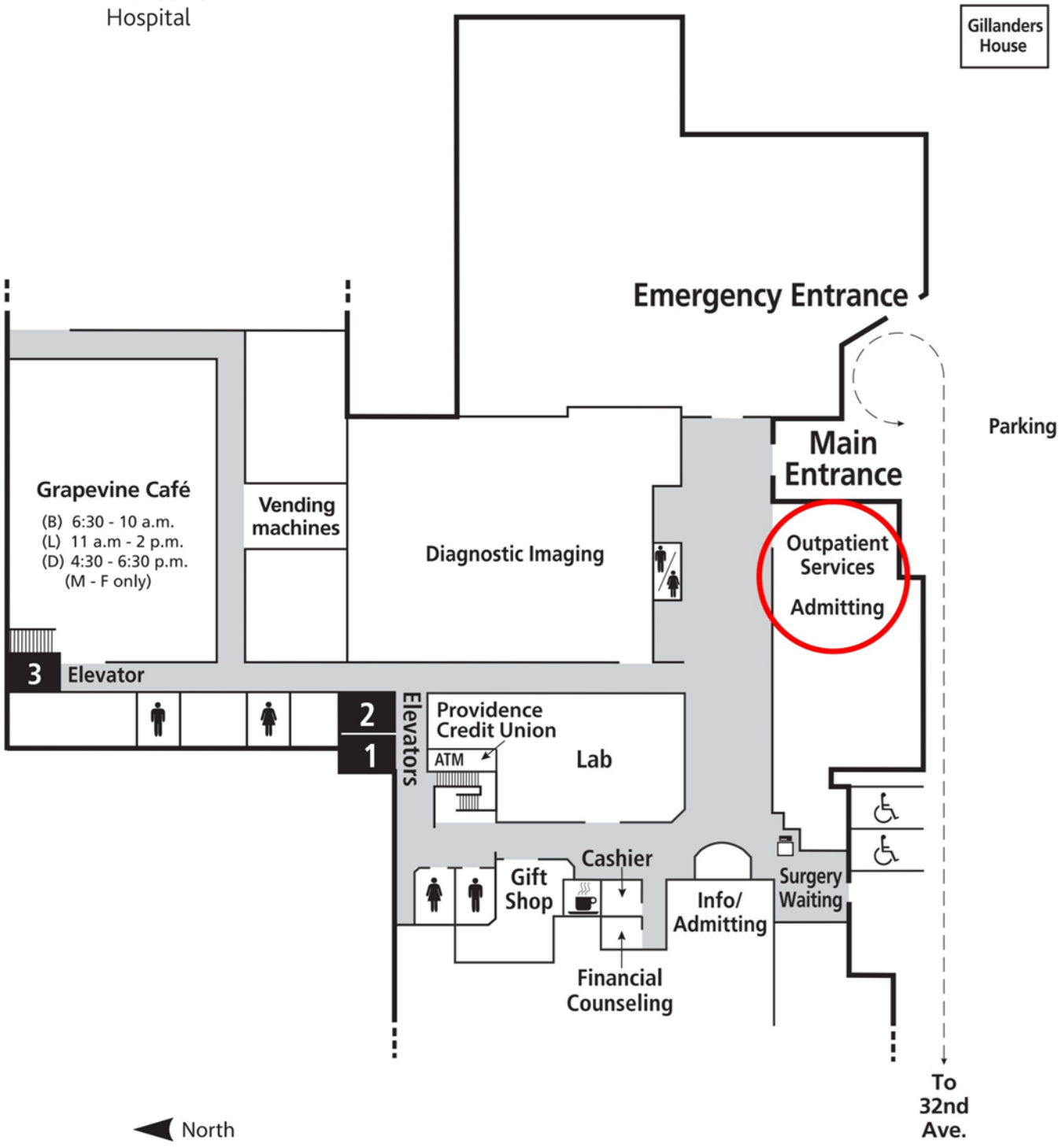
PROVIDENCE
Milwaukie
Hospital

1st Floor



To Johnson Creek Blvd. ← **32nd Ave.** → To Harrison St.

Providence Milwaukie Hospital, 10150 S.E. 32nd Ave., Milwaukie, Oregon 97222 • 503-513-8300
www.providence.org/pmh

PROVIDENCE
Health & Services

Thank you for choosing Providence Milwaukie Hospital to assist you in your care! You are scheduled for a surgery with a doctor from **Colorectal Health NW.** Please read the following instructions to help ease your way.

Before your procedure:

Please register as soon as you know your physician has arranged your procedure. We now offer online registration at www.providence.org/surgery or you may **call 503-215-9565 to register over the phone.** You will be asked to verify your insurance and provide some general information.

Location and Parking:

Providence Milwaukie Hospital is located at 10150 S.E. 32nd Ave Milwaukie, OR 97222. Please take the driveway (off of 32nd Ave) with the Main Entrance/Emergency Entrance sign. Park in the parking lot at the top of the hill on the right side. Go through the Main Entrance sliding glass door. Immediately on your left is the Outpatient Services/Admitting desk, check in there.

Please bring:

- Please complete and bring the 2 pages (front & back) of forms included. One is asking for your current list/dosages of medications. The other for your health history information.
- If you wear contact lenses bring your case and solution.
- Your reading glasses, hearing aids, and any mobility devices such as a cane or walker. Wheelchairs are available for use while you are at the hospital.

Please do not bring any valuables or wear any jewelry.

Due to fragrance sensitivity and potential allergic reaction we ask that you and your visitors please do not wear perfume, body spray, cologne or other fragrance while visiting the hospital.

Transportation:

****You MUST have someone drive you home. You CANNOT take a bus or taxi.**

Due to the short duration of the procedure, we recommend your driver stay on the hospital premises.

If you have any further questions you may contact your physician's office or contact Pre-Procedural Services at 503-513-8843.

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PROVIDENCE
Health & Services

PPMC - Providence Portland Medical Center
PSVMC - Providence St. Vincent Medical Center
PMH - Providence Milwaukie Hospital

PERSONAL MEDICATION FORM

PATIENT IMPRINT

Name:_____ Date of birth: _____ Date form last updated: _____ Page_____

Your complete medication history is important to your physicians and to the hospital. Please fill out this form and bring it with you anytime you go to the doctor's office or to the hospital. If you are scheduled for a Pre-Surgical Services appointment, make a trip to the Emergency Room, or are coming directly to the hospital - Remember to bring this completed form! If for some reason you are unable to fill out this form, please bring in a bag of all the medications (in their original containers) that you are currently taking.

Allergies: Are you allergic to medications, iodine, food, tape, or latex?

ALLERGY & REACTION	ALLERGY & REACTION
❑ No known allergies	

Vaccines: When did you last receive these vaccines? Check one box for each vaccine.

TETANUS	PNEUMOCOCCAL (Pneumovax)	INFLUENZA (Flu)	PEDIATRIC (For child)
❑ Less than 5 years ❑ Less than 10 years ❑ Over 10 years ❑ Never ❑ Unknown	❑ Received in past (month/year) _____ ❑ Never ❑ Unknown	❑ Date last received (month/year) _____ ❑ Never ❑ Unknown	❑ Up-to-date ❑ Never ❑ Unknown

Medications: Please list **all** prescription and non-prescription medications, herbals, eye drops, inhalers, etc. that you use.

NAME OF MEDICINE	DOSE (mg, units, puffs)	ROUTE (by mouth, eye drops)	DIRECTIONS	PURPOSE Why do you take it?

257899 8/08

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PROVIDENCE Health & Services

ADULT HEALTH STATUS SUMMARY

PATIENT LABEL

INFORMATION SOURCE: PATIENT / RESPONSIBLE PERSON SIGNATURE — USE PEN TO COMPLETE FORM

❑ Patient ❑ Other / Relationship _____

Signature: _____

WHEN DID YOU LAST EAT OR DRINK? _____

MEDICAL AND SURGICAL HISTORY

YES	NO		
❑	❑	**Have you been in the hospital in the last 30 days? If yes, why?** _____	
❑	❑	**Surgeries / Procedures / Births (list):**	**DATE**
❑	❑	**Prostheses / Implants (list – for example, Total Joint, AICD, Pacemaker, etc.):**	**DATE**

ANESTHESIA/TRANSFUSION HISTORY

❑	❑	I have had problems with previous ANESTHESIA: ❑ High fever ❑ Muscle weakness
❑	❑	I have a relative who has had problems with ANESTHESIA: ❑ High fever ❑ Muscle weakness
❑	❑	Previous blood transfusion?
❑	❑	Transfusion reaction?
❑	❑	I have an objection to blood transfusions: ❑ Religious objection ❑ Personal objection

SUBSTANCE USE	Denies	Uses	How Much / Often?	Date Last Use?	SUBSTANCE USE	Denies	Uses	How Much / Often?	Date Last Use?
Tobacco use in last 12 months				Quit Date	Meth / Amphetamines				Quit Date
Alcohol					Heroin				
Marijuana					IV Substance				
Cocaine					Other				

ADDITIONAL NARRATIVE NOTES

INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME	INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME	INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME

If questions about completing this form, please call:

PSVMC 503-216-1993
PPMC 503-215-1874
PMH 503-513-8843
PNMC 503-537-1450
PHRMH 541-386-3911
PMMC 541-732-5537
PSH 503-717-7239
PWFMC 503-650-6845

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PROVIDENCE Health & Services

ADULT HEALTH STATUS SUMMARY

PATIENT LABEL

YES	NO	Do you have or have you ever had:				
		Cancer:	Type: _____	How long ago? _____		
		Chronic Pain:	Chronic Pain History:			
		Neurological:	❑ Seizures	❑ Stroke	❑ TIA	❑ Numb areas
			❑ ALS	❑ Alzheimers	❑ Guillain-Barré	❑ Fainting	❑ Dizzy spells
			❑ Migraines	❑ Multiple sclerosis	❑ Myasthenia gravis	❑ Weakness	❑ Confusion
			❑ Parkinson's	❑ Head injury	❑ Spinal cord injury	❑ Paralysis	
		EENT:	❑ Cataracts	❑ Glaucoma	❑ Impaired vision	❑ Blind	❑ Dental bridges
			❑ Lens implants	❑ Glasses	❑ Contacts	❑ Artificial eye	❑ Dental caps	❑ Deaf
			❑ Impaired hearing	❑ Hearing aids	❑ Loose teeth	❑ Electrolarynx	❑ Dentures	
		Musculoskeletal:	❑ Back pain	❑ Arthritis	❑ Broken facial bones	❑ TMJ
			❑ Broken neck	❑ Broken pelvis	❑ Degenerative disease	❑ Broken back	
			❑ Cerebral palsy	❑ Fibromyalgia	❑ Muscular dystrophy	❑ Limited range of motion	
		Cardiovascular:	❑ Chest pain	❑ Heart attack	❑ High blood pressure
			❑ Blood clots	❑ Congenital defects	❑ Coronary artery disease	❑ Congestive heart failure
			❑ Murmur	❑ Defibrillator	❑ Pacemaker	❑ Irregular heart beat
			❑ Palpitations	❑ Mitral valve prolapse	❑ Peripheral vascular disease	
		Respiratory:	❑ Chronic bronchitis	❑ Chronic cough	❑ Sleep apnea
			❑ Asthma	❑ Tuberculosis	❑ Pneumonia	❑ Shortness of breath
			❑ Emphysema	❑ Upper resp. infection	❑ Chronic obstructive pulmonary disease	
		Gastrointestinal:	❑ GERD	❑ Diverticulitis	❑ Hiatal hernia	❑ Irritable bowel
			❑ Cirrhosis	❑ Ulcers	❑ Ostomy	❑ Intestinal bleeding	❑ Gall bladder disease
			❑ Hemorrhoids	❑ Hepatitis	❑ Pancreatitis	❑ Hyperemesis	❑ Inflammatory bowel
			❑ Frequent diarrhea	❑ Frequent constipation		❑ Jaundice	
		Renal / Urinary:	❑ Dialysis	❑ Kidney disease	❑ Incontinence
			❑ Frequent urinary tract infection		❑ Urostomy	
		Skin: ❑ Psoriasis	❑ Eczema	❑ Bruises easily	❑ Ulcer / wound
		Immune: ❑ Immune compromised		❑ HIV/AIDs	
		Reproductive:	❑ Child birth	❑ GYN problems	❑ Prostate problems	❑ STIs
		Pregnant? ❑ No ❑ Yes Est Gest Age: _____ wks			Last menstrual period _____	
		Birth control method: _____			Lactating? ❑ No ❑ Yes	
		Behavioral Health:	❑ ADHD	❑ Depression	❑ Bipolar disorder	❑ Obsessive compulsion disorder
			❑ Eating disorder	❑ Panic attacks	❑ Psychotic disorder	❑ Anxiety disorder	❑ Dementia
		Anemia / Bleeding:	❑ Anemia	❑ Bleeding disorder	❑ Sickle cell anemia
		Endocrine:	❑ Diabetes - insulin dependent	❑ Diabetes - oral agent	❑ Diabetes - diet controlled
			❑ Hyperthyroid	❑ Hypothyroid	

Other history: _____

_____

DISCHARGE PLANNING (OUT-PATIENT SETTINGS)

Discharge Transportation Provider:

❑ Same as Contact Person (page 1)

❑ Needs to be called when patient is ready to go home

❑ Will remain here at the hospital

❑ Is planning to return at: _____ (time)

Name: _____

Phone #1: _____ Phone #2: _____

INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME	INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME	INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME