Beth Israel Deaconess Hospital
Plymouth

Patient Profile - Review of Systems

Patients: Please answer all questions below. Print clearly and in ink. This will become part of your medical record.

Personal Medical History (Check any of the below conditions/problems that you have now or have had in the past.) ***BRING A COPY OF AN EKG FROM YOUR PRIMARY PHYSICIAN'S OFFICE.***

☐ High Blood Pressure	☐ Asthma	☐ Nausea/Vomiting	☐ Hepatitis ☐A ☐B ☐C ☐D
☐ A. Fib/Irregular Heartbeat	☐ Bronchitis/Emphysema/COPD	☐ Diarrhea	☐ Cirrhosis
☐ Chest Pain (explain)	☐ Sleep Apnea ☐ On CPAP	☐ Constipation	☐ Esophageal Varices
☐ Heart Failure	☐ Tuberculosis	☐ Heartburn/GERD	☐ Arthritis
☐ Heart Attack (explain)	☐ Kidney Disease	☐ Ulcers	☐ Osteoporosis
☐ Heart Murmur	☐ Thyroid Disease	☐ Hiatal Hernia	☐ Seizures
☐ Pacemaker/Internal Defibrillator	☐ HIV/AIDS	☐ Difficulty Swallowing	☐ Strokes (explain)
☐ Anemia	☐ Blood Clots (explain)	☐ Colitis/Crohns	☐ Cancer (explain)
☐ High Cholesterol	☐ Diabetes	☐ Abdominal Pain	☐ Weight Loss

Diabetes: If you check your blood glucose (sugar) at home, check and record it before arriving._____

Pregnancy: Are you pregnant now / not / don't know? ☐ Yes ☐ No ☐ Unknown
Do you feel safe at home? ☐ Yes ☐ No

Please further explain any checked boxes or list any other medical conditions:_____

Allergy History Circle all that apply:

☐ NO KNOWN ALLERGIES

Tape	Eggs	Shellfish
Iodine	Soy	Betadine
Latex	Peanuts	

Medication allergies *(List with reactions):*

_____

_____

_____

Social History *(Check the appropriate yes or no answer to the following.)*

Substance	Yes	No
Do you smoke?	☐	☐
If so, how much?		
Do you consume alcohol?	☐	☐
If so, how much?_____		
Do you use recreational drugs?	☐	☐
If so, how much?_____		

Please further explain any checked boxes:_____

Operation/Hospitalization History *(List all operations/hospitalizations)*

Year	Reason
_____	_____
_____	_____
_____	_____

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Current Medications *(List all medications such as prescription drugs, aspirin, oral contraceptives, vitamins, herbs, over the counter, etc.)*

Medication	Last Time Taken

I, _____ **(print name), verify that the above information is accurate to the best of my knowledge.**

Signature of Patient:_____ **Date:**_____ **Time:**_____

Nursing Use Only **Arrival Time**_____ ☐ In pt ☐ Out pt

Date_____ Arrival by ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Other

Pt identified by ☐ Name ☐ DOB

Current problem _____

Scheduled procedure _____

Pregnancy test ☐ Yes ☐ No

Result_____ Time_____ By_____

Reference (neg)_____

Blood Sugar (if applies)_____

Pre-procedural pain level (1-10)

Pain comments_____

Coag (if applies) Date_____

PT_____ INR_____

Ht._____ Wt._____

Contact person post procedure _____

Driver for discharge and telephone number _____

Procedure checklist	Yes	No	N/a
Previous testing using IV dyes	☐	☐	☐
Fasting	☐	☐	☐
Labs, EKG, CXR	☐	☐	☐
Previous problems with anesthesia/mod sedation	☐	☐	☐
Prep	☐	☐	☐
ID bracelet	☐	☐	☐
Risk for fall	☐	☐	☐
Glasses	☐	☐	☐
Dentures	☐	☐	☐
Jewelry	☐	☐	☐
Other	☐	☐	☐

If yes, explain_____

_____

_____

_____

I have reviewed and discussed the information above with the patient:

Signature of RN:_____ **Date:**_____ **Time:**_____