PRESBYTERIAN

Wound Center History Form – Ostomy Patient Pre-Op (Page 1)

How do you prefer to be addressed/ what name do you prefer? _____

What type of ostomy is planned: ☐ Ileostomy ☐ Colostomy ☐ Urostomy ☐ Unsure

Planned date of surgery: _____ Surgeon _____

Reason for the ostomy surgery? _____

Do you have any past experience of knowledge of ostomies? ☐ No ☐ Yes, please describe: _____

_____

Please list any previous abdominal surgeries _____

_____

Do you have any complications with your vision? ☐ No ☐ Yes, please describe: _____

Do you have any complications with your dexterity? ☐ No ☐ Yes, please describe: _____

What type of work/activities/exercise do you do? _____

Please list any questions you might have about an ostomy _____

_____

_____

_____

_____

How do you learn best? ☐ Reading ☐ Listening ☐ Watching ☐ Other _____

Do you smoke or use tobacco? ☐ No ☐ Yes, how much? _____

Are you on a special diet? ☐ No ☐ Yes, what type? _____

Is there any other information that will be helpful for us to know? _____

_____

_____

_____

Patient Identification

Patient Signature: _____

Reviewed by: _____ Date: _____

PRESBYTERIAN

Wound Center History Form – Ostomy Patient Pre-Op (Page 2)

In order for your ostomy provider to get a complete picture, please complete the following nutritional assessment and general history information below.

Nutrition Score: Please circle any answers that apply to you.

	Yes
I have an illness or condition that made me change the kind and/or amount of food I eat	2
I eat fewer than two meals per day	3
I eat few fruits and vegetables or milk products	2
I have three or more drinks of beer, liquor, or wine almost every day	2
I have tooth or mouth problems that make it hard for me to eat	2
I don't always have enough money to buy the food I need	4
I eat alone most of the time	1
I take three or more different prescribed or over-the-counter drugs a day	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months	2
I am not always physically able to shop, cook and/or feed myself	2
Total	

0-2 good, 3-5 you are at moderate nutritional risk, 6 or more you are at high nutritional risk

General History: please check "Yes" if these apply to you.

Legs	**Yes**		**Yes**		**Yes**
Swelling		Congestive Heart Failure		Transplanted organ	
Numbness		Coronary Artery Disease		Hepatitis or Cirrhosis	
Blood clots (DVT)		High blood pressure		Stomach ulcers	
Paralysis or weakness		Stroke		Skin cancers	
Trouble with walking		Heart Attack		Bone infection(s)	
Pain even without wound		Former smoker		Arthritis	
Poor circulation		Use oxygen		Incontinence or ostomy	
Previous surgery		Get short of breath		Thyroid problems	
Amputation(s)		Bleeding problems		Immune deficiency	
Joint replacement or other implant		Dialysis: *What is your schedule?*		Other *(explain):*	

Have you had **radiation** treatments (not x-rays)? ☐ No ☐ Yes
What body location?

Are you currently receiving **Chemotherapy**? ☐ No ☐ Yes

Do you have any specific customs, wishes or beliefs that might affect care? ☐ No ☐ Yes

Patient Signature: _____

Reviewed by: _____ Date: _____

Patient Identification