

D. Brent Rotton, D.O., FACOS Board Certified General Surgery

(All information is confidential)

Date: _____

Name: _____ Birthdate: ____/____/____ Age: ____

MEDICAL HISTORY Check (✓) the medical conditions you have or have had:			
<input type="checkbox"/> AIDS / HIV positive <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia / Bulimia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cancer <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diabetes Type? _____ <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Goiter <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia Site? _____ <input type="checkbox"/> Hypertension <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Kidney Stones <input type="checkbox"/> Liver Disease <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Pacemaker/Defibrillator <input type="checkbox"/> Pneumonia <input type="checkbox"/> Prostate problem <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide attempt	<input type="checkbox"/> Thyroid problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers Where? _____ <input type="checkbox"/> Other (please list below) _____ _____ _____ _____

SURGICAL HISTORY	
Year	Type of Surgery

Have you ever had a blood transfusion? Yes No If yes, give approximate date: _____

FAMILY HISTORY (Fill in health information about your family.)

	Age	State of Health	Age at Death	Cause of Death		Age	State of Health	Age at Death	Cause of Death
Father					Mother				
Brothers					Sisters				

Check (✓) if your blood relatives had any of the following.

<input type="checkbox"/> Arthritis, Gout <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes	<input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease, Strokes <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____
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SOCIAL HISTORY		
Check (✓) if your work exposes you to the following.	Check (✓) which substances you use and indicate how much you use per day/week.	
Hazardous substances	Caffeine	Drugs
Other	Tobacco	Alcohol

PHYSICAL EXAM - DICTATED

REVIEW OF SYSTEMS (Check (✓) the medical conditions you have or have had in the past year.)

GENERAL	GI/STOMACH	EYE, EAR, NOSE, THROAT	MEN (only)
<input type="checkbox"/> Chills / Fever	<input type="checkbox"/> Appetite Poor	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Breast Lump R / L
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating / Gas	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Erection Difficulties
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Constipation	<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Lump in Testicles
<input type="checkbox"/> Fainting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Difficult Swallowing	<input type="checkbox"/> Penis Discharge
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Sore on Penis
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Earache	<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Headache	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Ear Discharge	<input type="checkbox"/> Other
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Indigestion/Heartburn	<input type="checkbox"/> Hay Fever	
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Hoarseness	Women (only)
<input type="checkbox"/> Weight Gain/Loss	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Abnormal Pap Smear
	<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Bleeding between periods
MUSCLE / JOINT / BONE	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Breast Lump R / L
Pain, Weakness, Numbness in:	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Extreme Menstrual Pain
<input type="checkbox"/> Arms <input type="checkbox"/> Hips		<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Hot Flashes / Sweats
<input type="checkbox"/> Back <input type="checkbox"/> Legs	CARDIOVASCULAR	<input type="checkbox"/> Vision – Flashes	<input type="checkbox"/> Nipple Discharge
<input type="checkbox"/> Feet <input type="checkbox"/> Neck	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Vision – Halos	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<input type="checkbox"/> Chest Pressure		<input type="checkbox"/> Other
	<input type="checkbox"/> High / Low Blood Pressure	Skin	
GENITO-URINARY	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Bruise Easily	Over the Counter Medicines
<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Hives / Itching	<input type="checkbox"/> Herbal Supplement
<input type="checkbox"/> Lack of Bladder Control	<input type="checkbox"/> Swelling of Ankles	<input type="checkbox"/> Change in Moles	<input type="checkbox"/> Pain Medicine (Advil,Aleve)
<input type="checkbox"/> Painful Urination		<input type="checkbox"/> Scars	<input type="checkbox"/> Other
<input type="checkbox"/> Blood in Urine		<input type="checkbox"/> Sores that won't heal	

Anything else you feel the doctor needs to know? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form. I consent to examination/treatment/surgery if indicated by the physicians of Tahlequah City Hospital.

Signature: _____

Date: _____

Reviewed by: _____

Date: _____

Last name:		First name:		
Sex:	Age:	Weight, kg:	Height, cm:	Date:

Complete the screen by filling in the boxes with the appropriate numbers.
Add the numbers for the screen. If score is 11 or less, continue with the assessment to gain a Malnutrition Indicator Score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake

B Weight loss during the last 3 months
0 = weight loss greater than 3kg (6.6lbs)
1 = does not know
2 = weight loss between 1 and 3kg (2.2 and 6.6 lbs)
3 = no weight loss

C Mobility
0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out

D Has suffered psychological stress or acute disease in the past 3 months?
0 = yes 2 = no

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems

F Body Mass Index (BMI) = weight in kg / (height in m)²
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater

Screening score (subtotal max. 14 points)
12-14 points: Normal nutritional status
8-11 points: At risk of malnutrition
0-7 points: Malnourished
For a more in-depth assessment, continue with questions G-R

Assessment

G Lives independently (not in nursing home or hospital)
1 = yes 0 = no

H Takes more than 3 prescription drugs per day
0 = yes 1 = no

I Pressure sores or skin ulcers
0 = yes 1 = no

References

- Vellas B, Villars H, Abellan G, et al. Overview of the MNA[®] - Its History and Challenges. *J Nutr Health Aging*. 2006; **10**:456-465.
- Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF). *J. Gerontol*. 2001; **56A**: M366-377
- Guigoz Y. The Mini-Nutritional Assessment (MNA[®]) Review of the Literature - What does it tell us? *J Nutr Health Aging*. 2006; **10**:466-487.

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For more information: www.mna-elderly.com

J How many full meals does the patient eat daily?
0 = 1 meal
1 = 2 meals
2 = 3 meals

K Selected consumption markers for protein intake

- At least one serving of dairy products (milk, cheese, yoghurt) per day yes no
- Two or more servings of legumes or eggs per week yes no
- Meat, fish or poultry every day yes no

0.0 = if 0 or 1 yes
0.5 = if 2 yes
1.0 = if 3 yes

L Consumes two or more servings of fruit or vegetables per day?
0 = no 1 = yes

M How much fluid (water, juice, coffee, tea, milk...) is consumed per day?
0.0 = less than 3 cups
0.5 = 3 to 5 cups
1.0 = more than 5 cups

N Mode of feeding
0 = unable to eat without assistance
1 = self-fed with some difficulty
2 = self-fed without any problem

O Self view of nutritional status
0 = views self as being malnourished
1 = is uncertain of nutritional state
2 = views self as having no nutritional problem

P In comparison with other people of the same age, how does the patient consider his / her health status?
0.0 = not as good
0.5 = does not know
1.0 = as good
2.0 = better

Q Mid-arm circumference (MAC) in cm
0.0 = MAC less than 21
0.5 = MAC 21 to 22
1.0 = MAC greater than 22

R Calf circumference (CC) in cm
0 = CC less than 31
1 = CC 31 or greater

Assessment (max. 16 points)

Screening score

Total Assessment (max. 30 points)

Malnutrition Indicator Score

24 to 30 points	<input type="checkbox"/>	Normal nutritional status
17 to 23.5 points	<input type="checkbox"/>	At risk of malnutrition
Less than 17 points	<input type="checkbox"/>	Malnourished