

Do you now, or have you ever had problems with the following:

- | | | | |
|---|---|--|---|
| Yes No | Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes* | <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Seizure/Convulsions | <input type="checkbox"/> <input type="checkbox"/> CHF* |
| <input type="checkbox"/> <input type="checkbox"/> Asthma*/COPD/TB | <input type="checkbox"/> <input type="checkbox"/> Kidney/Bladder | <input type="checkbox"/> <input type="checkbox"/> Anesthesia complications | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Hepatitis/Liver | <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion Reaction | Are you currently: |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid | <input type="checkbox"/> <input type="checkbox"/> Mental Health | <input type="checkbox"/> <input type="checkbox"/> Heart/Circulation | <input type="checkbox"/> <input type="checkbox"/> Post Menopausal |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding/Clotting | <input type="checkbox"/> <input type="checkbox"/> Stomach/Bowel | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Pregnant or Breastfeeding |

*complete self assessment forms

Explain any yes: _____

<p>This area is to be filled out by the patient/significant other. Directions: Please answer the following questions. A nurse will review your answers to plan your care.</p> <p>Why have you come to the hospital? _____ What are your expectations of care, treatment and service while you are here? _____ _____ What questions do you have about your health/illness? _____ _____ Have you ever had any surgery? <input type="checkbox"/> yes <input type="checkbox"/> no List _____ _____ Any complications with surgeries? _____ What medications-(prescription or over the counter drugs, herbs, vitamins) are you taking? _____</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Name of Drug</th> <th style="width:20%;">dose & frequency</th> <th style="width:15%;">last taken</th> <th style="width:35%;">Purpose</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>Have you received a pneumococcal vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Influenza vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:60%;">Amount-# of years</th> <th style="width:40%;">Past History</th> </tr> </thead> <tbody> <tr> <td>Tobacco use: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td> </td> </tr> <tr> <td>Alcohol use: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td> </td> </tr> <tr> <td>Drug use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Review No Smoking Policy <input type="checkbox"/> Smoking Cessation Information</td> <td><input type="checkbox"/> cocaine <input type="checkbox"/> marijuana <input type="checkbox"/> drug using needles <input type="checkbox"/> heroine/methadone <input type="checkbox"/> other</td> </tr> </tbody> </table> <p>Has your doctor suggested a nutrition supplement such as Ensure, Boost, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any problems eating due to <input type="checkbox"/> chewing <input type="checkbox"/> swallowing <input type="checkbox"/> mouth pain <input type="checkbox"/> nausea/vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> NO PROBLEMS Have you lost your appetite for more than 5 days? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes why? _____ Have you had an unplanned weight loss of more than 10lbs in the past 2 mo.? <input type="checkbox"/> Yes <input type="checkbox"/> No What is your usual weight? _____ Type of diet followed at home: _____ Would you like more information about your special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Last bowel movement _____ Frequency _____ Do you use laxatives, enemas or any other medication for your bowels? <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Weekly <input type="checkbox"/> Daily Type _____ <input type="checkbox"/> Colostomy <input type="checkbox"/> Ileostomy <input type="checkbox"/> Urostomy Do you have problems urinating? <input type="checkbox"/> Yes <input type="checkbox"/> No or with Control? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Burning <input type="checkbox"/> Night-time <input type="checkbox"/> Other _____</p>	Name of Drug	dose & frequency	last taken	Purpose																													Amount-# of years	Past History	Tobacco use: <input type="checkbox"/> Yes <input type="checkbox"/> No		Alcohol use: <input type="checkbox"/> Yes <input type="checkbox"/> No		Drug use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Review No Smoking Policy <input type="checkbox"/> Smoking Cessation Information	<input type="checkbox"/> cocaine <input type="checkbox"/> marijuana <input type="checkbox"/> drug using needles <input type="checkbox"/> heroine/methadone <input type="checkbox"/> other	<p>This area to be filled out by the nurse.</p> <p style="text-align: center;"><u>Health Perception</u> <u>Health Management</u></p> <p>Date _____ Time _____ Room No. _____ Oriented to: <input type="checkbox"/> Call Light <input type="checkbox"/> Meal Times <input type="checkbox"/> Telephone/TV <input type="checkbox"/> Bed Operations/side rails Policies Explained <input type="checkbox"/> Visiting Hours <input type="checkbox"/> Electric Appliances <input type="checkbox"/> Smoking <input type="checkbox"/> Pt. Rights <input type="checkbox"/> Valuables Vital Signs Current Pain Rating _____ T _____ BP Rt _____ Lt _____ P _____ R _____ <input type="checkbox"/> ID band accuracy confirmed <input type="checkbox"/> Allergy form initiated <input type="checkbox"/> Allergy Band On <input type="checkbox"/> NA Signature _____</p> <p>Anticipated Learning Needs: <input type="checkbox"/> None <input type="checkbox"/> Disease Management <input type="checkbox"/> Procedure Instructions <input type="checkbox"/> Medications Social Service consult <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p style="text-align: center;"><u>Nutrition/Metabolic</u></p> <p>New dx diabetes of GDM Y N New onset dialysis Y N New Transplant Y N</p> <p>Any yes in above section requires referral to Nutrition Services: Consult SS/ET if stage III or IV ulcer Referral sent: <input type="checkbox"/> Nutr Svcs <input type="checkbox"/> SS <input type="checkbox"/> No referrals needed Anticipated Learning Needs: <input type="checkbox"/> None <input type="checkbox"/> Done <input type="checkbox"/> Mouth Care</p> <p style="text-align: center;"><u>Elimination</u></p> <p>Anticipated learning needs: <input type="checkbox"/> None</p>
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PATIENT COMPLETED ADMISSION HISTORY

Patient Label

<p>Before hospitalization did you need help with the following activities? If Yes need help of</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;"></th> <th style="width:10%;">No</th> <th style="width:10%;">Person</th> <th style="width:10%;">Device</th> <th style="width:15%;">Type of Device</th> <th style="width:40%;">Describe</th> </tr> </thead> <tbody> <tr> <td>Eating</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>crutches</td> <td>_____</td> </tr> <tr> <td>Bathing</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>cane</td> <td>_____</td> </tr> <tr> <td>Dressing</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>walker</td> <td>_____</td> </tr> <tr> <td>Walking</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>w/c brace</td> <td>_____</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>prosthesis</td> <td>_____</td> </tr> </tbody> </table> <p>Do you have stairs at home? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have problems with shortness of breath? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you tire easily? <input type="checkbox"/> Yes <input type="checkbox"/> No Trouble with your balance? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a history of falls? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		No	Person	Device	Type of Device	Describe	Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	crutches	_____	Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cane	_____	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	walker	_____	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	w/c brace	_____					prosthesis	_____	<p style="text-align: center;">Activities/Exercise</p> <p>Does current status/diagnosis affect patient functioning Y N Consider PT/OT consult</p> <p><u>Anticipated learning needs:</u> <input type="checkbox"/> None <input type="checkbox"/> Activity guidelines <input type="checkbox"/> Use of equipment</p>
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Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	crutches	_____																																
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				prosthesis	_____																																
<p>Memory changes? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe _____</p> <p>Vision Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> lens implants <input type="checkbox"/> R <input type="checkbox"/> L</p> <p>Hearing Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No Corrected with <input type="checkbox"/> Hearing aid <input type="checkbox"/> R <input type="checkbox"/> L</p> <p>What is the easiest way for you to learn? <input type="checkbox"/> seeing <input type="checkbox"/> listening <input type="checkbox"/> doing <input type="checkbox"/> reading</p> <p>Do you have difficulty with? <input type="checkbox"/> Reading <input type="checkbox"/> Yes <input type="checkbox"/> No Writing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have problems with? <input type="checkbox"/> Fainting <input type="checkbox"/> Dizziness <input type="checkbox"/> Tingling</p> <p><input type="checkbox"/> Telling hot from cold <input type="checkbox"/> Numbness <input type="checkbox"/> Headaches <input type="checkbox"/> NO PROBLEMS</p> <p>Describe _____</p> <p>Have you been having a problem with pain or discomfort during the past 2 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the pain assessment form.</p>	<p style="text-align: center;">Cognition</p> <p>Potential barriers to learning &/or communication <input type="checkbox"/> language <input type="checkbox"/> vision <input type="checkbox"/> hearing <input type="checkbox"/> other: _____</p> <p>Further assessment needed: <input type="checkbox"/> PT <input type="checkbox"/> not indicated</p> <p>Pain assessment form completed Y NA <input type="checkbox"/> Consult Case Management Services (CMS) for further assessment if any yes</p>																																				
<p>How would you rate your current anxiety? (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)</p> <p>Will this hospital stay create problems for you or your family? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, describe)</p> <p>Are you in a relationship where you are afraid of being hurt physically or emotionally? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, refer to case Mngt)</p> <p>In the past year have you ever been hit, slapped, kicked or physically hurt by someone? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, refer to case Mngt)</p> <p>Do you have an exit Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">Self Perception</p> <p style="text-align: center;">Coping/Stress Tolerance</p> <p><u>Anticipated learning needs:</u> <input type="checkbox"/> None <input type="checkbox"/> Relaxation techniques</p> <p><input type="checkbox"/> Consult Case Management Services (CMS) for further assessment if any yes</p>																																				
<p>Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No Will you be going home at discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you need help with <input type="checkbox"/> Shopping or <input type="checkbox"/> Cooking? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Who is able to help care for you when you leave the hospital? _____ Hours available _____</p> <p>Do you receive any type of health care at home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: _____</p> <p>Home Care Agency _____</p> <p>Do you need help arranging a ride home, MD's office, clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have any financial needs/concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">Discharge Planning Needs</p> <p><input type="checkbox"/> Transfer from ECF/assisted living <input type="checkbox"/> Concern about social issues <input type="checkbox"/> Anticipate continued therapy at D/C <input type="checkbox"/> Concerns about living situation <input type="checkbox"/> Anticipated services or equipment needed at home _____ <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> No needs requiring referral or other services identified at admission.</p> <p><input type="checkbox"/> Consult Case Management Services (CMS) for further assessment if any yes</p>																																				
<p>Do you have cultural/religious/spiritual practices needing special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please explain: _____</p> <p>Would you like to see a chaplain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">Value/Belief</p> <p>Adv dir copy on chart Y N NA Chaplain called Y N</p> <p>Immunizations up to date? Y N If not, please explain _____ _____ _____</p>																																				
<p>Is there any other information about yourself/family which you feel will help us plan your care and your discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																																					
<p>If 15-17 years of age: Legal guardian _____ Lives with _____</p> <p>Have you had: Chickenpox <input type="checkbox"/> Yes <input type="checkbox"/> No Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No Measles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recent exposures _____ Last tetanus shot _____</p> <p>Activities enjoy _____</p> <p>Grade in school _____ Name of school _____</p> <p>Learning difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No Specify _____</p> <p>Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																																					
<p>Signature of person completing form: _____ Date _____ Time _____</p>	<p>RN Signature _____ Date/Time _____</p>																																				

Information obtained from: _____ Relationship _____ Date _____ Time _____

Contact Person/Emergency Notification: _____ Phone# _____