

PLEASE HELP US TO MAKE YOUR STAY MORE COMFORTABLE BY COMPLETING THE UNSHADED PORTIONS OF THIS FORM

What language do you speak most commonly?  English  Spanish  Other: \_\_\_\_\_

What health problem brought you to the hospital today? \_\_\_\_\_

Admitting Diagnosis: \_\_\_\_\_  
 History of Present Illness: (i.e., present symptoms, when they started, factors making symptoms worse/better, previous episodes of similar symptoms, previous related tests/treatments, relevant personal health history.)  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have any allergies or intolerances to ANY medications, foods, tapes, dyes, or the environment?  YES  NO  
 (please list and describe reaction below)

ITEM	REACTION

ITEM	REACTION

Have you ever had any breathing problems or skin rashes when coming in contact with rubber or latex products?  NO  YES  
 Description of latex reaction: \_\_\_\_\_

Is there a chance you could be pregnant?  YES  NO  N/A. If YES, date of Last Menstrual Period: \_\_\_\_\_

Please list any prescription and/or over-the-counter medications you take. (Include vitamins, herbs, birth control pills, etc.)  NONE

NAME	DOSE	HOW OFTEN TAKEN	REASON FOR TAKING	TIME LAST TAKEN

Have you brought any medications (prescription or non-prescription, vitamins, herbs, supplements, or birth control pills) with you today?  YES  NO

Do you have a history of any of the following? (Check all that apply)  NONE

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Arthritis               |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Stroke/TIA     | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Anemia                  |
| <input type="checkbox"/> Heart Valve Disease      | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Emphysema/COPD     | <input type="checkbox"/> Kidney / Renal Problems |
| <input type="checkbox"/> Angina / Chest Pain      | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Prostate Problems       |
| <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Female Problems         |

Description of past medical history: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



HEALTH PERCEPTION - HEALTH MANAGEMENT PATIENT

Please list any serious illnesses, surgeries, or hospitalizations:  NONE

Year	Description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever received blood or blood products?

YES  NO

If YES, did you have a reaction?  YES  NO

Description of reaction: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list all physicians who provide care to you:

Physician Name	Specialty
_____	_____
_____	_____
_____	_____

Physician Name	Specialty
_____	_____
_____	_____

Height:  Stated  Measured Weight:  Stated  Measured

Do you now, or have you ever used any of the following?

	Never	Past	Present	TYPE	AMT/FREQ	LENGTH OF TIME	LAST USE
TOBACCO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
ALCOHOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
CAFFEINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____

Are you currently:  working  retired  
 a student  not working  disabled What is your current/former occupation? \_\_\_\_\_

Please check those items you wear or use, and those you brought with you to the hospital today.  NONE

Use or Wear	Brought to Hospital	Item	Use or Wear	Brought to Hospital	Item	Use or Wear	Brought to Hospital	Item
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid (Left)	<input type="checkbox"/>	<input type="checkbox"/>	Dentures (Upper)	<input type="checkbox"/>	<input type="checkbox"/>	Cane
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid (Right)	<input type="checkbox"/>	<input type="checkbox"/>	Dentures (Lower)	<input type="checkbox"/>	<input type="checkbox"/>	Crutches
<input type="checkbox"/>	<input type="checkbox"/>	Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Dentures (Partial)	<input type="checkbox"/>	<input type="checkbox"/>	Walker
<input type="checkbox"/>	<input type="checkbox"/>	Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Braces, type: _____	<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Prosthetics, type: _____			

Do you have an Advance Directive (Living Will, Power of Attorney for HEALTHCARE)?  YES  NO

If NO Advance Directive,  Information Provided

If YES, did you bring it with you today?  YES  NO Date Advance Directive placed in Chart: \_\_\_\_\_

Plan to obtain Advance Directive if not brought at admission: \_\_\_\_\_

If you DON'T have an Advance Directive, who, other than you, knows your wishes related to health care?

OR

If you DO have an Advance Directive NOT BROUGHT WITH YOU today, who did you name as your agent/decision maker?

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_

CHECK here if you have any specific wishes regarding your health care and write them on the back of this form.

**Please update Advance Directive information in SAM**

In the event of an emergency, who would you like us to contact?

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Phone #: \_\_\_\_\_

Questions deferred due to:

- Patient's Clinical Status (1)
- Knowledgeable Informant Unavailable (2)
- Other \_\_\_\_\_ (3)

- PATIENT ACCEPTS RESPONSIBILITY FOR BELONGINGS
- BELONGINGS SENT HOME
- LOCKER
- VALUABLES SENT TO SAFE AND RECEIPT ON CHART

Patient Oriented to Room

**NUTRITION/METABOLIC**  
Deferral Code

What diet do you follow? (Check all that apply)

No Special Diet                       Low Calorie  
 Vegetarian                               Low-Fat Diet  
 Diabetic                                       Low Salt (Sodium)  
 Kosher                       Other (please specify): \_\_\_\_\_

Have you had any recent changes in your eating habits or appetite?  
 YES\*    NO

Have you lost 10 or more pounds in the last 3 months?  YES  NO  
 If YES, was this loss intentional?  YES  NO\*

Do you have difficulty with:  
 Chewing  YES\*  NO / Swallowing  YES\*  NO  
 If YES, please describe: \_\_\_\_\_

\* Indicates patient may be at "nutritional risk". In-depth nutritional screen should be ordered via SAM Infogram. Check when sent

**ELIMINATION**  
Deferral Code

Do you have any of the following problems with your bladder/urination?  
 (Check all that apply)

No Problems                               Blood in Urine  
 Dribbling                                       Painful Urination  
 Urgency                                       Frequency  
 Up at night                                       Loss of control/incontinence  
 Other (please describe): \_\_\_\_\_

Do you have any of the following problems with your bowels?  
 (Check all that apply)

No Problems                               Loss of control/incontinence  
 Constipation                                       Diarrhea  
 Hemorrhoids

When was your last bowel movement? \_\_\_\_\_  
 Please describe any laxatives or methods you use to help you have a bowel movement.  
 \_\_\_\_\_

**ACTIVITY/EXERCISE**  
Deferral Code

Check any of the following activities you need assistance with:  None

Toileting                                       Dressing  
 Bathing                                       Walking  
 Climbing Stairs                                       Feeding Yourself

Have you required increased assistance with the above activities during the past month?  NO  YES\*

\* Indicates need for functional evaluation, obtain MD Order for "Therapy Eval".

Do you have enough energy to do the things you want to do?  
 YES  NO If NO, please describe: \_\_\_\_\_

Do you exercise?  YES  NO If YES, how often \_\_\_\_\_  
 If YES, what type: \_\_\_\_\_

**SLEEP/REST**  
Deferral Code

When do you sleep?  Night  Day  
 What helps you sleep? \_\_\_\_\_

Do you have problems with any of the following? (Check all that apply)

No Problems                               Waking up early  
 Falling asleep                                       Staying asleep  
 Snoring                                       Sleep Apnea

**SOURCE OF INFO.**

(Check all that apply)

Patient    Family Member    Friend    MD H & P    Transfer Form    Interpreter used    Prenatal Records  
 Previous Patient Profile of Hosp. Admission Date: \_\_\_\_\_  
 Copy placed in chart    No changes in status    See this form for changes

**SEXUALITY**  
Deferral Code

Do you have concerns about how your illness/surgery will affect your sexual function?  YES  NO  
 If YES, please describe: \_\_\_\_\_

**COGNITIVE/LEARNING SENSORY/PERCEPTUAL**  
Deferral Code

Do you have difficulty with any of the following? (Check all that apply)  
 Hearing  Learning  Seeing  Speaking  No Problems

Are you currently having any pain or discomfort?  YES  NO  
 If YES, has the pain/discomfort lasted:  
 less than 3 months    more than 3 months

What part of your body is your pain located in? \_\_\_\_\_

On a scale of 0-10, with 0 equaling no pain, and 10 equaling the worst pain you've ever had, circle the number which best indicates your pain right now: NONE 0 1 2 3 4 5 6 7 8 9 10 MAXIMUM

What helps your pain? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

**VALUE/BELIEF**  
Deferral Code

Will being in the hospital make it difficult for you to carry out your religious, spiritual, or cultural practices?  YES  NO  
 If YES, please describe: \_\_\_\_\_

Would you like the Hospital Chaplain to visit you?  YES  NO  
 Would you like your clergy person notified of your admission?  
 YES  NO

**ROLE RELATIONSHIP**  
Deferral Code

Do you have any concerns about how your illness/hospitalization will affect your life? (Check all that apply)  None

At home                                       In your church  
 With your family                                       At school/work  
 Other: \_\_\_\_\_

If so, please describe your concerns if you are able:  
 \_\_\_\_\_

Who do you rely on for emotional support?  
 Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
 Is there anyone or anything that makes you feel unsafe or uncomfortable in your home environment?  YES  NO If YES, please explain:  
 \_\_\_\_\_

**SELF-CONCEPT**  
Deferral Code

Has the illness/hospitalization caused any changes in your appearance or abilities that affects the way you feel about yourself?  
 YES  NO If YES, please describe your feelings if you are able:  
 \_\_\_\_\_

**COPING/STRESS**  
Deferral Code

How have you been coping emotionally with your current illness and being in the hospital?  Very well  Good  Fair  Poorly  
 Is there anything we can do to assist you in coping?  YES  NO  
 If YES, what can we do? \_\_\_\_\_

What else do you wish to tell us about yourself that would help us to care for you? \_\_\_\_\_

Nurse's Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
 Nurse's Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

