Overnight Patient Admission

Name: ____

List All Surgeries/Procedures: ______________________________
____
____
Patient History of Cancer: ______________________________
Family History of Cancer: ______________________________

Last Pneumonia Vaccine: ____________ Last Flu Vaccine: ____________
Last Tetanus: ______________ Hepatitis Vaccine: ______________
Home Medications: Yes: _____ No: _____ N/A: _____

Medication:	**Dose:**	**Frequency:**	**Last Taken:**

Eye, Ears, Nose & Throat
Impaired Vision: ____________ Hard of Hearing: ____________
Glaucoma: ____________ Cataracts: ____________
Sinus Infection: ____________ Tonsilectomy: ____________
Voice Changes: ____________
Any Eyes, Ears, Nose & Throat Surgeries: ______________________
____
Is there any family history of any of the above: ______________
Explain: ______________________________________
____

Neurological
Alzheimer's/Organic Brain Syndrome: ______________________
Paralysis: ________ Tremors: ____________ Parkinson's: ____________
CVA/TIA: ________ Migraines/Headaches: ______________________
Epilepsy/Seizures: ______________ Mental Illness: ____________
Neurological Comments: ______________________________
____
Is there any family history of any of the above: ______________
Explain: ______________________________________
____
____

Respiratory

TB: _________ Asthma: ______________ Lung Disease: _________ Bronchitis: _____________

Cystic Fibrosis: ______________ Home Equipment: _______________________________________

Is there any family history of any of the above: ____

Explain: ____

____

____

Endocrine

Diabetic: ___________ Controlled by: ____

Family History: ____

If diabetic. Have you ever attended diabetic education classes:_________________________

Thyroid: ____

Endocrine Comment: ____

Cardiovascular

Palpitations: _____ Pacemaker: _____ Angina: _____ Heart Attack: ______ Bypass: ______

Congestive Heart Failure: ______________ Coronary Artery Disease: _____________________

Hypertension: ______________ Peripheral Vascular Disease: ______________________________

Stent: ___________ Heart Cath: ______________ Angioplasty: ______________________________

Cardiovascular comment: ____

Is there family history of any of the above: ____

Explain: ____

____

____

Gastrointestinal

Constipation: __________ Bloody Stools: ___________ Mucous Stools: ___________________

Regular use of laxatives/Other Aids: ____

Colostomy/Ilestomy: __________ Ulcers: ______________ Diverticulitis: ________________

Pancreatitis: _______________ Hepatitis: _______________ Cirrhosis: _________________

Hiatal Hernia: ______________ Hemorrhoids: _____________ Colitis: _____________________

Obstruction: _______________ Jaundice: ________________ Appendectomy: _______________

Gall Bladder Surgery: ___________________ Bowel Surgery:_____________________________

Hysterectomy: _____________________

Gastrointestinal comment: ____

Is there family history of any of the above: ____

Explain: ____

____

____

Urinary System

Foley: ___________ Prostate Surgery: _______________ Prostatitis: ____________________

Kidney Stone: ______________ Dialysis: ____

Urinary Comment: ____

Is there family history of any of the above: ____

Explain: ____

____

____

Reproduction
Last menstrual period: ______________________________
Vaginal Bleeding: ____________ Discharge: ____________
Fetal Heart Tones: ______________________________
Reproduction Comment: ______________________________

Muscular
Deformity: __________ Swelling: __________ Stiffness: __________
Fractures: __________ Arthritis: __________ Prosthesis: __________
Contractures: ____________ Amputee: ____________
Joint Replacement: ______________________________
Other Ortho Surgery's: ______________________________
Muscular comment: ______________________________
____

Skin Integrity
Itching: __________ Rash: __________ Ecchymosis: __________
Petechiae: __________ Abrasion: __________ Wound: __________
Decubitus: ______________________________
Description of any of the above: ______________________________
____
____
Skin comment: ______________________________

Psycho Social
Smoke: __________ Alcohol Intake: __________ Education Level: __________
Psycho-Social Support: ______________________________
Primary Language: ______________________________
Have you ever had a blood transfusion: ______________________________
Do you object to blood transfusion: ______________________________
Any cultural/religious factors that may affect your care: ______________
____

Learning Needs
Is patient able to learn: ______________________________
Barriers to learning-cultural/religious: ______________________________
Emotional: ____________ Desire/Motivation: ____________
Cognitive: ____________ Language: ____________
Can patient read: ____________ Can patient write: ____________
Hearing loss: ______________________________
Patient education comment: ______________________________
Comment: ______________________________
Patient preference for learning:
Auditory: __________ Visual: __________ Tactile: __________
If patient of school age will they need assistance with school work: ____________
If parents unavailable was social services notified: ____________

Safety Factors

Impaired Mobility: ____________________ Frequent Falls: ____________________

New onset unexplained weakness: ____________________

Recent injury/surgery resulting in functional deficit: ____________________

Adult Admission Assessment

List any allergies: ____________________

____

Any latex allergies: ____________________

Food allergies: ____________________

Pain

Do you have pain now: ____________________

Have you had pain in the last several weeks or months: ____________________

Location of pain: ____________________ Which side: ____________________

What relieves the pain: ____________________

Pain is worsened by: ____________________

What effect has the pain had on:

Activities of daily living: ____________________

Sleeping: ____________________

Eating: ____________________

Relationships with others: ____________________

Work: ____________________

Enjoyment of life: ____________________