

**PATIENT HISTORY QUESTIONNAIRE**  
(complete within 24 hours)

Patient label

Date \_\_\_\_\_ Time of Admission: \_\_\_\_\_

Preferred name: \_\_\_\_\_ Age: \_\_\_\_\_

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ (to be completed by Nursing)

LIST ALLERGIES AND YOUR REACTION	
<b>Food Allergies</b> 🍌	<b>Reaction</b>
<b>Drug Allergies</b> R	<b>Reaction</b>
<b>Other Allergies</b>	<b>Reaction</b>

Do you have allergies to balloons, rubber, kiwi or strawberries?  Yes  No Describe:

If "YES" complete Latex Sensitivity Questionnaire

MEDICAL HISTORY	YES	NO
<b>Have you had...</b>		
Anemia/Bleeding Problems/Blood Clots?		
Heart Problems/Angina?		
High Blood Pressure?		
Stroke/Head Injury/Brain Disease?		
Has this affected your ability to speak, comprehend?	👤	
Seizures?		
Glaucoma/Vision Problems?		
Thyroid Problems?		
Breathing/Lung Problems/Asthma?		
Tuberclucosis?		
Were You Treated?		🚑
GI Problems/Ulcers?		
Unintentional weight loss >= 10 lbs. in 2 mo.?	🍌	
Difficulty eating for > than 7 days?	🍌	
Liver Problems/Hepatitis?		
Kidney/Renal Problems?		
Prostate Problems?		
Cancer?		
Depression?		
MRSA/VRE?		🚑
Hospital admission within the last 30 days?		
Flu Vaccine? Date Given _____		
Pneumonia Vaccine? Date Given _____		

HAS ANYONE IN YOUR FAMILY HAD:	YES	NO
Heart Problems?		
High Blood Pressure?		
Cancer?		

FEMALE (Childbearing age)	YES	NO
Are you pregnant?		
Are you breastfeeding?		
First day of last menstrual period:		

FUNCTIONAL MOBILITY STATUS		
If your ability to perform these activities has declined in the past 7 days, mark the appropriate box(es).		
<input type="checkbox"/> None	<input type="checkbox"/> Walking	<input type="checkbox"/> Contractures
<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Moving from place to place
<input type="checkbox"/> Other: 👤 _____		
<input type="checkbox"/> Eating	<input type="checkbox"/> Brushing Teeth	<input type="checkbox"/> Bathing/Dressing
<input type="checkbox"/> Other: 🍽️ _____		
Make a referral for any box checked.		

ANESTHETIC HISTORY	YES	NO
Date of last anesthetic:		
Any abnormal reactions?		
Describe reaction:		
Any relatives with abnormal reactions to anesthetic?		

PREVIOUS SURGERY	YES	NO
<b>Type of Surgery</b>		
<b>Date</b>		

DO YOU HAVE?	YES	NO
Night sweats?	🚑	
Extended persistent cough?	🚑	
Cough up blood?	🚑	
An infection?	🚑	
Nasal problems?		
Mouth sores?		
Difficulty swallowing/Taking pills?	👤	
Ostomy?		
Nutrition formula by tube or IV?	🍌	
Need for special diet education?	🍌	
History of a transplant?	📄	
Your name on a transplant list?	📄	

DO YOU?	YES	NO
Smoke? (No. Packages a day _____)	🚬	
Have you stopped smoking within the last year?	🚬	
Use smokeless tobacco?	🚬	
Use alcoholic beverages?		
Use caffeine?		
Object to blood transfusions?		
Object to blood for life-threatening conditions?		

**PAIN ASSESSMENT**

NO Pain with this illness

**PAIN SCALE - FACES RATING**

0 Absent 1 2 3 4 Moderate 5 6 7 8 9 10 Worst possible

Pain level at present is: \_\_\_\_\_

What number is acceptable to you? (target no.) \_\_\_\_\_

Location of Pain: \_\_\_\_\_

Describe Pain: \_\_\_\_\_

Comfort Measures Used Before Coming to Hospital \_\_\_\_\_

SCAN FRONT AND BACK TO PHARMACY - Date, Time and Initials:

Patient label

**LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING THOSE NOT PRESCRIBED BY YOUR DOCTOR**

See Home Medication Reconciliation Form. (Include all psychotropic meds, OTC, including ASA, herbals, eye & ear drops.)

PSYCHOSOCIAL ASSESSMENT	YES	NO
Are you currently being treated for any mental health conditions?	*	
Are you a transfer from an inpatient psychiatric facility?	*	
Have you had thoughts of hurting or killing yourself in the past 24-48 hours?	*	
Have you had or are you being treated for a recent suicide attempt?	*	

\* If there are any "Yes" responses, follow Suicide Precaution Flow Chart.

FALLS ASSESSMENT	YES	NO
History of falls?		
History of fainting?		
History of excessive urination at night?		
History of bowel or bladder urgency?		
Do you have confusion/disorientation?		
Do you have difficulty walking?		
Do you have poor vision?		
Are you hard of hearing?		
Are you currently taking medications?		
Do you have difficulty communicating?		

DIABETES ASSESSMENT	YES	NO
Have you ever been told that you have diabetes or high blood sugar? (If yes, nursing staff provides and teaches the Survival Skills booklet.) <input type="checkbox"/> Check box if Survival Skills booklet given to patient.		

Have you gone through diabetes education within the last 3 years? (If no, nursing staff obtains physician signature on Diabetes Center Out-Patient Education Prescription Form and forwards to DC via FAX 231-3786.)		
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SPIRITUAL STATUS	YES	NO
Do you have any cultural, spiritual or dietary practices you would like considered?		
Please describe:		
Would you like Chaplain services?		

LEARNING NEEDS ASSESSMENT	YES	NO
Is English your primary language?		
If not, what is your primary language _____		
What is the highest level of education you have completed? _____		
How do you learn best? (circle) reading, seeing, hearing, doing		
What do you need to know about your condition? (circle) Medication, Special diet, Lifestyle change, Equipment, Community Resources, Other _____		

SOCIAL STATUS
Living Situation: <input type="checkbox"/> Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Apt. <input type="checkbox"/> Assisted Living <input type="checkbox"/> Other
Living Arrangement: <input type="checkbox"/> Alone <input type="checkbox"/> With Spouse <input type="checkbox"/> Other: _____
Primary Care Giver: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Paid Attendant
Is there anyone who can help with your care at home if needed? <input type="checkbox"/> Yes <input type="checkbox"/> No  Name _____
Are others dependent on you? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever used a Home Health Agency? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Agency: _____
Have you recently been a victim of verbal, physical or sexual abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL EQUIPMENT
Do you currently have any medical equipment at home? Provided by:
<input type="checkbox"/> Oxygen _____
<input type="checkbox"/> Wheelchair _____
<input type="checkbox"/> Hospital Bed _____
Other _____

Signature of person completing form: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ R.N. Date/Time: \_\_\_\_\_