PATIENT HEALTH ASSESSMENT

HC HENRY COUNTY
MC MEDICAL CENTER

Patient Name: _____

Date of Admission or Procedure:_____

PATIENT INSTRUCTIONS:

Please complete all sections on each page or have someone complete it for you. Answer by CIRCLING when appropriate. Please bring this completed form with you to your Preadmission Testing appointment.

PERSONAL INFORMATION

Patient Name:_____

Admitting Physician or Surgeon:_____

Person providing information: self spouse parent child other_____

Relationship:_____ Date:_____

Language spoken: English Spanish Other_____

Is an interpreter needed? YES NO

Name and phone # of interpreter: _____

Do you have a living will? YES NO UNKNOWN

Do you have a durable power of attorney for healthcare? YES NO UNKNOWN

If "yes": Name Phone #_____

(If "yes" to above question, please bring a copy to the hospital on admission.)

Are you an Organ Donor? YES NO UNKNOWN

Primary Physician Name:_____ Phone #_____

REASON FOR ADMISSION (please describe): Surgery Physical Therapy Speech Therapy

Other_____

_____

ANY IMPLANTS/ DEVICES/PUMP/ STIMULATOR IN YOUR BODY

YES (TYPE)_____ NO

ALLERGIES

NONE MEDICATIONS LATEX FOOD OTHER

List Allergies and Reactions:

_____

_____

_____

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Height_____ Current weight _____Actual _____ Estimated_____ Weight 1 yr. ago _____

Alcohol Use: Denies Current Past

beer liquor wine Other:_____

Drinks socially _____ per day _____per week

Tobacco use: Denies Current Past

cigarettes cigars pipe chew

How many cigarettes do you smoke a day?_____

Do you have a cigarette within one hour of awakening? YES NO

Illicit drug use: Never Past Now

Are you undergoing any treatments: Not applicable

Chemotherapy Radiation Peritoneal Dialysis Dialysis Antibiotics in past month

Other _____

Immunizations:

Tetanus/Yr _____Flu vaccine/Yr _____Pneumonia vaccine/ Yr_____

Other/Yr_____

Medications taken regularly (Prescription, over the counter, home remedies): None

Name of medication	**Dose (Amount you Take)**	**How many times a day**

List additional medications on additional sheet of paper

Herbal preparations: _____

Have you had any changes in medication in the past 30 days? YES NO

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RESPIRATORY/LUNGS:

NO PROBLEMS

Asthma	Loud snoring	CPAP	COPD
Sleep apnea	Cancer _____	Pneumonia	TB
Chronic bronchitis	Positive TB test	Tracheotomy	
Chronic cough/cough with mucus	Recent cold or flu	Wheezing	
Emphysema	Shortness of breath	Home Qxygen	

VASCULAR/HEART:

NO PROBLEMS

Abnormal EKG	Heart attack	Palpitations	Pacemaker
Blood clots	Heart blockage	Phlebitis	
Cancer _____	Heart murmur	Swelling of feet/ankles/legs	
Chest pain	High/Low blood pressure	Valve disorder	
Chest Pressure	Internal defibrillator	Varicose veins	
Circulation problems	Irregular heart beat	Other_____	

NEUROLOGICAL/BRAIN/SPINAL CORD

NO PROBLEMS

Fainting episodes	Alzheimers	Fainting	Seizures
Back pain	Frequent headache	Severe headaches	
Cancer _____	Memory problems	Speech slurred	
Difficulty learning	Mini stroke	Stroke	
Difficulty speaking	Neck pain	Tingling of arm/leg L R	
Difficulty with balance	Numbness	Weakness	
Dizziness	Paralysis of arm/leg L R Other_____		

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GASTROINTESTINAL/BOWEL/DIGESTIVE:

NO PROBLEMS

Bowel obstruction	Crohn's disease	Irritable bowel	Weight Loss _____
Cancer _____	Excessive burping	Jaundice	Colostomy
Chronic diarrhea	Heartburn	Pancreatitis	Hiatal Hernia
Cirrhosis of liver	Hemorrhoids	Rectal bleeding	Ulcer
Colitis	Hepatitis	Nausea/vomiting	Other_____
Diverticulum	Reflux/GERD		

MUSKULOSKELETAL:

NO PROBLEMS

Constipation	Iliostomy	Amputations _____
Arthritis	Lupus	Sciatica
Artificial joint(s)	Muscle disease	TMJ pain or jaw disorder
Cancer _____	Muscle weakness	Fracture
Osteoporosis	Gout	Pins, Rods, Internal Fixators
Fibromyalgia	Other_____	

ENDOCRINE:

NO PROBLEMS

Cancer _____	
Diabetes	Hormone disorder
Low blood sugar	Thyroid disorder
Other_____	

BLOOD:

NO PROBLEMS

Anemia	Immunosuppressed
Blood transfusion	Easy bruising
Cancer _____	
Frequent nose bleeds	

PSYCHIATRIC:

NO PROBLEMS

Anger	Eating disorder	Schizophrenia	Anxiety
Hallucinations	Suicide attempt	Dementia	Manic depression
Depression	Mood swings	Other_____	

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SKIN:

NO PROBLEMS

Bed sore	Shingles	Ulcerations	Rashes
Non-healing sores	Skin Cancer	Psorasis	Skin Disorder

Other_____

URINARY/REPRODUCTIVE

NO PROBLEMS

Blood in urine	Loss of control	**Females:**
Burning	Pain	Last Menstrual period:_____
Cancer _____	Prostate Problems (males)	Pregnant:
Difficult urination	Self Catheterization	Yes No Unsure
Frequent urination	Sexually transmitted diseases	Weeks pregnant_____
Urinary Diversion		
Infections	Urinary catheter (presently)	Due Date_____
Kidney stones	Ureterostomy	Breast Feeding

EYES/EARS/NOSE/THROAT:

NO PROBLEMS

Blind	Deaf	Hearing impairment
Cancer	Deviated septum	Ringing in ears
Cataracts	Glasses	Sinus problems
Contact lenses	Glaucoma	TTY needed
Corneal Implants	Hearing aids	

OPERATION PROCEDURES: None

List all surgeries and approximate dates:

_____

_____

_____

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ANESTHESIA:

NO PROBLEMS

Never had anesthesia

You or a blood relative had unexplained fever right after surgery (maglignant Hyperthermia)

Difficult intubation, problems with airway/breathing

Difficulty waking up from anesthesia

You required ventilator after surgery

Blood relative required ventilator after surgery

Severe nausea after surgery

DENTAL HISTORY:

NO PROBLEMS

Braces

Broken Teeth

Caps

Loose Teeth

Implants

Missing Teeth

Dentures:

Upper: *Full* *Partial*

Lower: *Full* *Partial*

NUTRITION:

NO PROBLEMS

Special Diet:	No restrictions		
Cardiac	Diabetic	Kosher	Thick It
Chopped/soft	Feeding tube	Low salt diet	Vegetarian
Cultural-specific diet	Fluid restriction	Renal	

Have you lost weight recently without trying? No Unsure Yes

If yes, how much weight have you lost? 1-5 lbs (1 point) 6-10 lbs (2 points) 11-15 lbs (3 points)

> 15 lbs (4 points) Unsure(2 points)

Have you been eating poorly because of a decreased appetite?

No (0 points) Yes (1 point) Total screening score:_____

ADJUSTMENT TO ILLNESS:

Request for Support or Counseling: Please check all those that apply.

Coping strategies	Medical advocate	Psychiatric crisis	Support group
Family issues	Pastoral Care	Social Work	Work issues

Are there any cultural, religious, or spiritual beliefs that we need to know in order to provide care for you? Yes No

Are there any spiritual needs that we need to address while you are in the hospital? Yes No

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DISCHARGE/DISPOSITION:	**SELF CARE:** No problems

Living Arrangements – Patient lives in:

Apartment

House

Personal care facility

Skilled nursing facility

Long term care facility

_____

Needs help with:

Bathing

Cooking

Dressing

Eating

Homemaking

Toileting

_____

Patient lives with:

Alone

Adult Child

Parent

Private aide

Sibling Home

Spouse

Friend/Other

Name of Person: _____

Phone # _____

Support available at home:

Full-time

Part-time

Undetermined

No help available

Place patient is planning to go at discharge:

Home

Preadmission Residence

Rehab Facility _____

Person Responsible for transportation home:

Name of Person:_____

Phone #_____

Has 24-hour companion at home: Yes No

Family

Friend

Spouse

Attendant (private aide)

_____

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CURRENT HOME CARE SERVICES/EQUIPMENT:

NOT APPLICABLE

Day Care	Nursing Care	Physical Therapy	Speech Therapy
Hospice	Occupational Therapy	Social Worker	Assisted Living

Name of Agency:_____

Patient Uses:

Cane	Hospital bed	Wheelchair
Commode	Oxygen Therapy	Name of company:_____

MOBILITY/ACTIVITY:

Grab bar	Tub bench	Walker
Ambulatory / Walks well alone	Independent	Requires assistance

Supervision:	**Assistive Devices Used:**		**Prosthetic device:**
Minimal	Cane	Walker	_____
Moderate	Crutches	Wheeled walker	_____
Maximum	Hemicane	Wheelchair	_____
Patient is bed bound	_____		

Communications level/Devices:

Normal Impaired

Please state anything else you think we should know:

_____

_____

_____

_____