

I. Patient Information

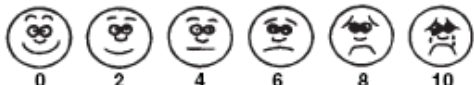
Time Admission: _____ Admitted from: _____
Chief Complaint/Associated Symptoms: _____

Ht. _____ Wt. _____ lb/kg Standing Scale Bed Scale Stated
Temp _____ Pulse _____ Resp _____ BP _____ Patient Identification Band on? Yes No
Emergency Contact: _____ PMD _____

II. Allergies Latex Sensitivity No Known Allergies Nickel or Jewelry Allergy
If yes, Allergy Band on: Yes No Charted Labeled: Yes No Entered into Computer Yes No
Food/Drug/Substance _____ **Type of Reaction** _____

III. Medications See attachment
Medications you are now taking, including: Non-Prescription, Aspirin, Birth Control Pills/Vitamins/Supplements/Herbal Remedies.
Drug/Dosage/Route _____ **Last Dose** _____

Personal Medications None Sent Home Inpatient Pharmacy Bedside

IV. Pain Assessment: Unable to obtain pain history due to patient condition.
Do you have any ongoing pain problems? Yes * No, If yes, where _____
Do you have pain now? Yes* No If yes, where _____
*If yes to either of the above describe your pain: aching burning cramping crushing dull pounding sharp
 shooting sore stabbing tender tingling throbbing other _____
How often do you have pain (frequency)? _____
How long does the pain last (duration)? Continuous Intermittent With Movement
How long have you had this pain? _____
Using one of the following scales, indicate your present level of pain: now _____ at worst _____ at best _____
What level of pain is acceptable to you? _____
LEVEL OF PAIN
0 1 2 3 4 5 6 7 8 9 10
No Hurts Hurts Hurts Hurts Hurts Hurts Hurts Hurts Hurts Hurts
Hurt Little Bit Little More Even More Whole Lot Worst

What causes or increases your pain? _____
What, if any, treatment(s) do you receive for your pain? _____
Is the treatment effective? Yes No Are the pain medications effective? Yes No
What impact does the pain have on your life and daily functioning? _____

V. Social Profile
Religious/Cultural Needs: _____ Primary Language Spoken: _____
Interpreter Needed? No Yes If Yes, Specify: _____
Employed/Occupation: _____
Out of Country Recently? No Yes Where/When? _____

VI. Psychological Profile
Alcohol use Yes No How much? _____ Last used: _____
Recreational drug use: Yes No Type & how much? _____ Last used: _____
Victim of violence/abuse: Yes* No Physical Verbal Emotional Mental
Are you thinking of taking your own life? Yes * (Contacting attending MD) No
History of Alcohol abuse Drug abuse Victim of violence abuse Suicide attempt
*If yes, referral to Social Work. Yes _____

PATIENT IDENTIFICATION

Name

Last, First

DOB / /
Mo/Day/Year

**INOVA HEALTH SYSTEM
ADULT PATIENT ADMISSION HISTORY**

Date: _____

VII. Advance Directive Screening:
Do you have a living will or any other document which expresses your wishes or authorize another person to make treatment decisions in the event you are unable to do so? (A two-part document in which the patient gives instructions about his or her health care and/or identifies a designated decision maker when the patient cannot speak for him or herself.)

YES Copy of Advance Directive on chart **OR**
 If no copy immediately available, ask patient to provide a copy

No **Would the patient like more information on Advance Directives:** Yes No
 If yes, Booklet given

PATIENT UNABLE TO RESPOND Family member contacted: _____ Date: _____ Initials: _____
 Patient has Advanced Directive per family Family member above will bring Advance Directive to hospital

Comment: _____
If not Next of Kin available, social work consult ordered in computer – Date: _____ **Initials:** _____

Are you an organ donor? Yes No Request info Information Given

VIII. Nutritional Screening
 Check box for all that apply:
 UNINTENTIONAL weight loss > 10lbs. past month
 Tube Feeding/TPN at home
 Fistula/Pressure Ulcer stage 3 >
 Pregnant/Lactating woman (on med/surg unit)
 Nonelective surgical admit >80 years
 Unable to take food 5 days prior to admission
 Unable to chew or swallow
 Initials: _____
If any criteria checked, order nutrition consult in computer. Date: _____ Initials: _____

Check box if no criteria apply; no consult required.
 Food Intolerances: _____ (Entered by CLN command)

IX. Functional Screening (not required for rehab or joint replacement patients, as therapy orders are part of routine admission orders)
Yes **NA**
 The patient has new onset decreased ability to move in bed, get out of bed, stand up, or walk and is likely to improve with Physical Therapy intervention.
 The patient has new onset decreased ability to perform activities of daily living (ADL's) and is likely to improve with Occupational Therapy intervention.
 The patient has new onset of decreased ability to swallow, as indicated by history of aspiration pneumonia, coughing, or drooling and is likely to improve with Speech Therapy intervention
 The patient has new onset of decreased ability to communicate secondary to neurological disorder, tracheostomy, and/or laryngectomy and is likely to improve with Speech Therapy intervention.
If any criteria checked, obtain PT/OT or Speech Therapy consult order.

X. Falls Screening (check all that apply & implement Adult Fall Interventions for any box checked)

	Points		Points		Points
<input type="checkbox"/> History of falls	(15)	<input type="checkbox"/> Urgency/Incontinence	(15)	<input type="checkbox"/> Age (older than 70 years)	(5)
<input type="checkbox"/> Confusion	(15)	<input type="checkbox"/> Dizziness/Postural Hypotension	(15)	<input type="checkbox"/> Mobility/Unable to ambulate independently	(5)
<input type="checkbox"/> ↑ anxiety/emotional lability	(5)	<input type="checkbox"/> Sensory deficit	(5)	<input type="checkbox"/> Medications affecting blood pressure or level of consciousness	(5)
<input type="checkbox"/> ↓ Level of cooperation	(5)	<input type="checkbox"/> Cardiovascular or Respiratory disease affecting perfusion & Oxygenation	(5)		

Score Total 15 or more points = High Risk Identification.

XI. Discharge Planning Do you have someone to assist you after discharge? No Yes
 Do you have medical equipment at home/Specify: _____
Patient/Family Living Situation: Home Independent Home/Family Care Home/Healthcare Mental Health Inst
 Retirement Community Assisted Living Skilled Nsg Fac Name of Fac. _____ Other: _____
Social Resources: None Unknown Spouse/Partner Parent(s) Child(ren) Other Family
 Home Health Substitute Decision Maker Mental Health Service(s) Dept. of Family Services Outpatient Health Clinic
 Other: _____ Comments: _____
 What complimentary therapies do you use? none chiropractor acupuncture aromatherapy other

PATIENT IDENTIFICATION

Name

 Last, First

DOB / /
 Mo/Day/Year

INOVA HEALTH SYSTEM
ADULT PATIENT ADMISSION HISTORY

Date: _____

XII. Have you ever had, or do you have any of the following? Check only if applicable.

ANESTHESIA HISTORY NA **YES** If Yes, Describe

Received Anesthesia		
Anesthesia Problems		
Relatives w/anes. problems		

Previous Operations/Hospitalizations

Date	Reason

CARDIOVASCULAR NA **YES** If Yes, Describe

Chest Pain/Angina		
Congestive Heart Failure		
Phlebitis/Deep Vein Thrombosis/(Blood Clot in leg)		
Edema/Swelling		
Hypertension/High BP		
Heart Attack (MI)		
Murmer/Mitral Valve Prolapse		
Pacemaker/Defibrillator		

RESPIRATORY NA **YES** If Yes, Describe

Asthma, Bronchitis, COPD Emphysema, Pneumonia		
Fatigue, Night Sweats, Tuberculosis		
Sore Throat, Cough, Cold in last 2 weeks?		Duration?
Tobacco Use	Pk/Day: Yrs.	# of
Stopped Tobacco Use:		When:
Smoking Cessation Counseling given		
Oxygen Therapy, Recent Sputum Changes		

NEUROLOGICAL NA **YES** If Yes, Describe

Alzheimer's/Dementia		
Seizures		
Mental Status Changes		
Migraines, Headaches, Head Injury		
Neuromuscular Disease		
Neurovascular Disease		
Sleep Disturbances		
Stroke/TIA		
Syncope/Fainting		

VASCULAR ACCESS NA **YES** If Yes, Describe

AV fistula, Hickman, Mediport, Groshong, PICC...

--	--	--

ENDOCRINE/METABOLIC NA **YES** If Yes, Describe

Diabetes/Hypoglycemia		
Pituitary/Adrenal Disease		
Thyroid Disease		

GASTROINTESTINAL NA **YES** If Yes, Describe

Change in Bowel Routine		
Constipation/Diarrhea		
GI Bleed		
Hemorrhoids		
Hiatal Hernia/Reflux		
Liver Disease/Hepatitis		
Nausea/Vomiting		
Ostomy		
Pancreatitis		
Ulcer Disease		

PATIENT IDENTIFICATION

Name

Last, First

DOB / /
Mo/Day/Year

**INOVA HEALTH SYSTEM
ADULT PATIENT ADMISSION HISTORY**

Date: _____

XI. (continued) Have you ever had, or do you have any of the following? Check only if applicable.

HEMATOLOGIC/ONCOLOGIC NA YES If Yes, Describe

Anemia/Sickle Cell		
Blood/Clotting Disorders		
Cancer/Tumors		
HIV Infection		
Past Blood Transfusions/ Adverse Reactions	Antibodies _____ Reaction _____	

PSYCHOLOGICAL NA YES If Yes, Describe

Anxiety/Panic Disorder		
Have you ever had a history of psychiatric or emotional problems?		

RENAL/GENITOURINARY NA YES If Yes, Describe

Blood in Urine		
Incontinence		
Kidney Disease/Dialysis		
Penile Discharge/Lesion		
Prostate Disease		
Sexually Transmitted Disease		
Stones/Obstruction		

Voiding Aids: Ostomy Self Cath Indwelling Cath

INTEGUMENTARY NA YES If Yes, Describe

Pressure Ulcer/Leg Ulcer/ 3rd degree burn		
Eczema/Psoriasis		

MUSCULOSKELETAL NA YES If Yes, Describe

Arthritis/Joint Pain		
Joint Replacement/ Any Prosthetic Devices		
Assistive Devices		
Back/Neck Pain		
Fractures		
Unable to Weight Bear		

DENTAL NA YES If Yes, Describe

Caps, Crowns, Chipped or Loose Teeth		
Dentures/Bridgework/Retainer		
Loose Teeth		

EYES/ENT NA YES If Yes, Describe

Hearing Deficits/Aids		
Nose Bleeds		
Sinus Disease		
Swallowing Difficulties		
Visual Deficit/Glasses/Contacts		
Glaucoma, Cataracts, Retinal Disease		

OBSTETRIC/GYN NA YES If Yes, Describe

Possibility of Pregnancy		L.M.P date:
# of Pregnancies _0_		
# of Live Births ___0__		
Menopause		
Breast Changes		
Mammogram		Date:
Pap Smear		Date:
Menstrual Problems		
Vaginal Discharge		

Reason unable to complete within the first 24 hours: _____

Signature: _____

Date: _____ Time: _____

Thank you for Completing this Form

Information from: patient significant other
 previous records transfer forms

Initiated by: _____

Completed by: _____

Reviewed by: _____ **RN**

Date: _____ Time Completed: _____

PATIENT IDENTIFICATION

Name

Last, First

DOB / /
Mo/ Day/ Year

**INOVA HEALTH SYSTEM
ADULT PATIENT ADMISSION HISTORY**

Date: _____