

DO YOU HAVE/USE?	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?		
Dentures?		
<input type="checkbox"/> Full Upper <input type="checkbox"/> Full Lower		
<input type="checkbox"/> Partial Upper <input type="checkbox"/> Partial Lower		
Loose Teeth?		
Caps?		
Hearing Aids? <input type="checkbox"/> R <input type="checkbox"/> L		
Contact Lens? <input type="checkbox"/> R <input type="checkbox"/> L		
Eye Glasses?		

DO YOU?	YES	NO
Smoke? (No. pkgs. a day _____)		
Have you stopped smoking within the last year?		
Use smokeless tobacco?		
Use alcoholic beverages?		
Amount used in last 24 HOURS _____		
Do you use recreational drugs?		
Amount used in last 24 HOURS _____		
Use caffeine?		
Object to blood transfusions?		
Object to blood for life threatening conditions?		
Donate Own Blood this Surgery?		

PAIN ASSESSMENT

NO Pain with this illness

PAIN SCALE FACES RATING

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

	YES	NO
Has pain at rest or pain that awakens at night		
Pain increases with initiation of activities		
Pain increases with weight bearing		
Pain interferes with activities of daily living		
Takes NSAIDs or meds to deal with discomfort		

Patient Label

DIABETES ASSESSMENT	YES	NO
Have you ever been told that you have diabetes or high blood sugar?		
Have you gone through diabetes education within the last 3 years?		

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 _____		
Do you need an interpreter?		
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
Any major stressful events present in your life? <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 _____

Patient label

CURRENT SYMPTOMS

Do you presently have any of the following complaints or symptoms?

	Yes	No		Yes	No		Yes	No
Fever			Sputum/Phlegm Prod.			Vomiting		
Poor Appetite			Trouble Breathing			Stomach Pain		
Recent Wt. Loss _____ #			Wheezing			Trouble Swallowing		
Recent Wt. Gain _____ #			Coughing up Blood			Vomiting Blood		
Unusual Thirst			Chest Pain			Diarrhea		
Difficulty Sleeping			Chest Tight/Pressure			Constipation		
Feel Unusually Tired			Heart Palpitations			Blood in Stools		
Trouble Sleeping			Swelling			Black Stools		
Easy Bruising			Leg Pain			Urinating Frequently		
Skin Rash			Freq/Severe Headache			Burning or pain with Urinating		
Itching			Dizziness/Lightheaded			Difficulty Urinating		
Changing Skin Mole			Black Out Spells			Blood in Urine		
Unusual skin Growth			Seeing Double			Discharge from Penis		
Trouble Seeing			Memory Loss			Vaginal Bleeding		
Wear Glasses			Numbness or Tingling			Vaginal Discharge		
Pain in Eyes			Loss of Balance			Vaginal Itching		
Trouble Hearing			Muscle Weakness			Abnormal Menstrual Period		
Wear Hearing Aid			Tremor			Breast Lump		
Ringing in Ears			Personality Change			Back Pain		
Earache			Feel Nervous			Joint Pain/Stiffness		
Nose Bleeds			Feel Depressed			Joint Swelling		
Persistent Hoarseness			Feel Suicidal			Neck Pain		
Cough			Nausea			Muscle or Body Ache		
Sore Throat								

MENTAL HEALTH HISTORY	YES	NO
Alcohol Abuse?		
Anxiety?		
Bipolar?		
Depression?		
Drug Abuse?		
Eating Disorder?		
Obsessive Compulsive Disorder?		
Psychosis?		
Schizophrenia?		

Patient label

PSYCHOSOCIAL ASSESSMENT	YES	NO
Are you a transfer from an inpatient psychiatric facility?		
Are you here because you tried to hurt yourself?		
In the past 6 months, have you been having thoughts of killing yourself?		
In the past 6 months, have you ever tried to hurt yourself?		

Note: If **ANY** of the above questions is answered "Yes", then the RN must complete the below assessment.

FOR STAFF RN TO COMPLETE (If indicated above)			
Note: LMHP may complete this section in OP Behavioral Health Departments.			
Does the patient have current Suicidal Thoughts and/or a plan?	Yes	No	Explain in Comments:
Suicidal Thoughts			
Suicidal Thoughts with a plan			
If response is YES to Suicidal Thoughts or Suicidal Thoughts with Plan, initiate the below:			
Suicide Precautions Continuous Observation initiated			
Mental Health Admission contacted for evaluation			Name:
Physician Order obtained for Suicide Precautions			
Name of Physician notified of suicidal thoughts/plan:			Time:

Personal Belonging Checklist (SA734) must be completed; valuables should be given to family or secured by calling Security. Behavioral Medicine will utilize designated Belonging Checklist based on area.

Signature of person completing form: _____

Reviewed by _____

