



NH1164

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

# NORTHSIDE HOSPITAL

Date of Visit: \_\_\_\_\_

## PERSONAL INFORMATION

Name: \_\_\_\_\_ Age \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 Home Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Emergency Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Language: English primary language?  Yes  No Primary Language: \_\_\_\_\_

## PHYSICIAN INFORMATION

Referring Physician: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Medical Oncologist: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Surgeon: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 PCP: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## HISTORY OF PRESENT ILLNESS

Stated reason for visit: \_\_\_\_\_  
 What were your initial symptoms? \_\_\_\_\_  
 When did they begin? \_\_\_\_\_  
 Who did you initially see to address the problem? \_\_\_\_\_  
 Which of the following have been done to investigate the problem?

Test	Date	Location	Test	Date	Location
CT/CAT Scan			PET Scan		
MRI			Bone Scan		
Mammogram			Colonoscopy		
Biopsy			Bronchoscopy		
Surgery			Other (please list)		

Have you ever had chemotherapy?  Yes  No  
 If so, list the type of chemotherapy given: \_\_\_\_\_  
 Dates of treatment: \_\_\_\_\_ Date of last treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Have you ever had radiation therapy?  Yes  No  
 If so, what area was treated: \_\_\_\_\_  
 What were the dates of treatment: \_\_\_\_\_ Name of Facility \_\_\_\_\_

## MEDICATIONS

Medication	Dose	Frequency	Prescribed By

## ALLERGIES

None  Contrast dye  Latex  Surgical Tape  Seasonal allergies  Shellfish

Medication Allergy	Type of Reaction

**IMMUNIZATION HISTORY**

For patients aged 50 or greater: Have you had a flu vaccine this season (Oct - Feb)?  Yes  No  Unknown  
 For patients aged 65 or greater: Have you had a pneumonia vaccination?  Yes  No  Unknown

**MEDICAL HISTORY** (Please check any of these you have been diagnosed with and indicate the year diagnosed)

✓	Check Here	Year	✓	Check Here	Year
	Angina			Cystitis or Bladder Infections	
	Heart Attack			Kidney Stones	
	Heart Failure			Kidney Failure	
	Irregular Heart Beat			Diabetes or sugar	
	Heart Murmur			Skin Condition	
	High Blood Pressure			Thyroid disease or Goiter	
	High Cholesterol			Arthritis	
	Glaucoma			Lupus	
	Chronic Bronchitis/Emphysema			Scleroderma	
	Tuberculosis			Other Collagen Disease	
	Asthma			Anemia	
	Hernia			Blood Clots or Clotting Disorder	
	Ulcers of Stomach or Duodenum			HIV or AIDS	
	Gallbladder Disease			Seizures or Epilepsy	
	Hepatitis or Liver Disease			Parkinson's Disease	
	Pancreatitis			Multiple Sclerosis	
	Ulcerative Colitis			Other Neurologic Problems	
	Crohn's Disease			Severe Anxiety	
	Irritable Bowel Syndrome			Depression	
	Diverticular Disease			Psychiatric Treatment	
	History of Colon Polyps			Stroke or paralysis	
	Other, please list				

**PAST SURGICAL HISTORY**

Type of Surgery	Date of Surgery	Surgeon	Hospital	Complications

**FAMILY HISTORY OF CANCER**

Relation to you	Type of cancer	Age diagnosed	Treatment	Alive/Deceased	Age

Other medical problems that run in the family: \_\_\_\_\_

**GYNECOLOGIC HISTORY** *Females Only*

Age at first menses: \_\_\_\_\_ Last menstrual period: \_\_\_\_\_ Age at menopause: \_\_\_\_\_  
Age at first pregnancy: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_  
Duration of birth control pill use: \_\_\_\_\_ Duration of hormone replacement therapy (HRT): \_\_\_\_\_  
Bra Size: \_\_\_\_\_ Age at first mammogram: \_\_\_\_\_ Date of last mammogram/location: \_\_\_\_\_  
GYN Problems/Infections: \_\_\_\_\_  
Are you sexually active?  Yes  No If yes, age when you became sexually active: \_\_\_\_\_

**MALE HISTORY** *Males Only*

Age at first PSA: \_\_\_\_\_ Is your PSA checked regularly?  Yes  No  
Are you sexually active?  Yes  No  
If yes, do you have impotence or difficulty with erections (erectile dysfunction)?  Yes  No  
Have you had a TURP (Roto-rooter)?  Yes  No  
If yes, what was the date of the surgery? \_\_\_\_\_  
How many times do you urinate during the night? \_\_\_\_\_  
Have you had prostate infections?  Yes  No  
If yes, what are the dates of the infection? \_\_\_\_\_  
Please indicate if you take any of the following medications  Viagra  Levitra  Cialis  Proscar  Avodart  Cardura  
 Hytrin  Flomax  Lupron  Casodex  Zoladex  Flutamide  Other \_\_\_\_\_

**SOCIAL HISTORY**

Personal Situation:  Married  Single  Widowed  Divorced  Separated  
If married, is spouse dependent upon you for care?  Yes  No  
Children's ages Boys: \_\_\_\_\_ Girls: \_\_\_\_\_  
Are your children dependent upon you for care?  Yes  No  
Living Situation:  Home  Apartment  Mobile Home  Nursing home  Assisted living  
How many people live with you? \_\_\_\_\_ Any pets? \_\_\_\_\_  
Education:  High school (Highest grade completed \_\_\_\_\_)  Trade School  College  Graduate School  
Current Work Situation:  Full-time  Part-time  Medical leave  Retired  Disability  
Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_  
Tobacco Use:  None  Cigarettes  Cigars  Snuff/Chew  Pipe  
How old were you when you started smoking? \_\_\_\_\_ How many years have you smoked? \_\_\_\_\_  
Are you still smoking?  Yes  No If no, when did you quit? \_\_\_\_\_  
If yes, how many packs per day do you smoke? \_\_\_\_\_ Are you interested in quitting?  Yes  No  
Alcohol Use:  None  Beer  Wine  Liquor  
How old were you when you started drinking? \_\_\_\_\_ Do you have a history of alcohol abuse?  Yes  No  
Are you still using alcohol?  Yes  No If no, when did you quit? \_\_\_\_\_  
If yes, how many drinks do you have per week? \_\_\_\_\_ Are you interested in quitting?  Yes  No  
Drug Use:  None  Marijuana  Cocaine  Heroin  Amphetamines  
How old were you when you started using drugs? \_\_\_\_\_ Do you have a history of drug abuse?  Yes  No  
Are you still using drugs?  Yes  No If no, when did you quit? \_\_\_\_\_  
If yes, how often do you use drugs? \_\_\_\_\_ Are you interested in quitting?  Yes  No  
Please describe any emotional/spiritual/cultural practices that may influence your medical care (i.e., blood transfusions):  
\_\_\_\_\_  
Please describe any financial concerns that may influence your medical care: \_\_\_\_\_  
Please describe any transportation concerns that may influence your medical care: \_\_\_\_\_  
Do you have concerns about your safety, the safety of anyone in your home, or the security of your property?  Yes  No

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## NORTHSIDE HOSPITAL

**REVIEW OF SYSTEMS** *(Please circle what symptoms you are currently experiencing. If none, then please circle "none")*

<b>General:</b>	Weight gain	Weight loss	Fatigue	Fever	Chills	Night sweats	None
<b>Eyes:</b>	Vision loss	Double vision	Blurry vision	Floaters	Black spots	Peripheral vision loss	None
<b>Ears, Nose:</b>	Decreased hearing	Earache	Vertigo	Decreased smell	Sinus trouble	None	
<b>Mouth:</b>	Mouth pain	Dental problems	TMJ	Oral ulcers	None		
<b>Throat:</b>	Hoarseness	Change in voice	Difficulty swallowing	Painful swallowing	None		
<b>Heart:</b>	Chest pain or pressure	Irregular heart beat	Difficulty lying flat	Ankle swelling	None		
<b>Lung:</b>	Shortness of breath	Cough	Coughing up blood	Pain with inspiration	None		
<b>Gastrointestinal:</b>	Nausea	Vomiting	Abdominal pain	Diarrhea	Constipation	Gas	Black stool
	stool	Bloody stool	Loss of appetite	None			
<b>Urinary:</b>	Pain with urination	Burning with urination	Blood in urine	Incontinence	Frequent urination		
	Weak urine stream	Night-time urination	None				
<b>Gynecologic:</b>	Vaginal discharge	Bleeding	Itching	Pelvic pain	Painful intercourse	None	
<b>Breast:</b>	Swelling	Pain	Nipple discharge	Skin changes	Lumpy breasts	Breast mass	None
<b>Musculoskeletal:</b>	Joint pain	Muscle pain	Bone pain	Decreased range of motion	None		
<b>Neurologic:</b>	Numbness	Tingling	Weakness	Seizures	Headache	Imbalance	Dizziness
	Tremor	Decreased coordination	Difficulty walking	None			
<b>Skin, Hair:</b>	Itching	Rashes	Ulcers	Change in skin color	Hair Loss	None	
<b>Hematologic/Lymphatic:</b>	Swollen lymph glands	Decreased blood counts	Easy bruising	None			
<b>Psychiatric:</b>	Depression	Anxiety	Claustrophobia	Trouble Sleeping	Irritability	None	
<b>Handicaps:</b>	Wheelchair	Walker	Cane	Oxygen dependant	Physical restrictions	None	

**Pain:** Are you experiencing pain?  Yes  No  
 Please rate your pain on a scale of 0-10 (0= no pain, 10 = worst pain): \_\_\_\_\_  
 Where is your pain? \_\_\_\_\_  
 What makes the pain better? \_\_\_\_\_  
 What makes the pain worse? \_\_\_\_\_  
 Does your pain interfere with your daily functioning? \_\_\_\_\_  
 Please describe your pain. \_\_\_\_\_

**Other Symptoms Not Listed Above:** \_\_\_\_\_

**Do you have a pacemaker?**  Yes  No      **Could you be pregnant?**  Yes  No  
**Do you have a history of falls?**  Yes  No      **Are you claustrophobic?**  Yes  No

**BOTTOM PORTION TO BE COMPLETED BY NURSE ONLY**

<b>VITALS:</b>	B/P _____	P: _____	R: _____	T: _____	Wt: _____	Ht: _____
ASSESSED NEEDS	IDENTIFIED PROBLEMS	REFERRAL ACTIONS TAKEN				
<b>Discharge Planning</b>	<input type="checkbox"/> Unable to care for self at home <input type="checkbox"/> No arrangements made for transportation post procedure	<input type="checkbox"/> Referral sent to Case Management/Social Services <input type="checkbox"/> Arrangements already made by patient/family <input type="checkbox"/> Patient declines referral <input type="checkbox"/> No needs identified <input type="checkbox"/> MD notified				
<b>Functional</b>	<input type="checkbox"/> Unable to ambulate without assistance <input type="checkbox"/> Needs assistive device training	<input type="checkbox"/> Referral sent to Physical Therapy <input type="checkbox"/> Arrangements already made <input type="checkbox"/> Patient declines referral <input type="checkbox"/> No needs identified <input type="checkbox"/> MD notified				
<b>Nutritional</b>	<input type="checkbox"/> Anorexia <input type="checkbox"/> Obesity	<input type="checkbox"/> Referral given for OP Nutritional Services <input type="checkbox"/> Arrangements already made/family <input type="checkbox"/> Patient declines referral <input type="checkbox"/> No needs identified <input type="checkbox"/> MD notified				
<b>Social</b>	<input type="checkbox"/> Suspected abuse/domestic violence/neglect	<input type="checkbox"/> A/N: Referral sent to Case Management/Social Services patient's request <input type="checkbox"/> A/N: Referral to Case Management/Social Services declined <input type="checkbox"/> MD notified				

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

Nurse/Physician Signature \_\_\_\_\_ Date \_\_\_\_\_