



NH1164

AFFIX PATIENT LABELS OVER THIS BOX

↓ BAR CODE MUST FALL BETWEEN THESE LINES ↑

NORTHSIDE HOSPITAL

PERSONAL INFORMATION			
Name:	Date of Birth:	Age:	
Home Address:			
Home Ph:	Work Ph:	Cell Ph:	
Emergency Contact Person:		Relationship:	Phone:
Language: English primary language? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, primary language:	
How did you hear of us?			

PHYSICIAN INFORMATION		
Referring Doctor:	City/State:	Phone:
Medical Oncologist:	City/State:	Phone:
Surgeon:	City/State:	Phone:
Primary Care Doctor:	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? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Facility:					
If yes, list the type of chemotherapy given:					
Dates of treatment:			Date of last treatment:		
Have you ever had radiation therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Facility:					
If yes, what area was treated:					
Dates of treatment:			Date of last treatment:		
PLEASE BRING ALL MEDICATION AND SUPPLEMENTS YOU ARE CURRENTLY TAKING					

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 Cause of Death	Age Death

Other medical problems that run in the family:
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MEDICAL HISTORY (Please check any of these you have been diagnosed with and indicate the year diagnosed)

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

Any previous history of cancer?
Please explain: _____

GYNECOLOGIC HISTORY *Females Only*

Bra Size: _____ Age at first mammogram: _____ Have you ever had an abnormal mammogram? Yes No

Age at first menses: _____ Age at first pregnancy: _____

Method of birth control: _____ Are you sexually active? Yes No

Are you currently on or ever taken hormone replacement therapy (HRT)? Yes No

GYN Problems/Infections: _____

COULD YOU BE PREGNANT? Yes No Last menstrual cycle: _____

MALE HISTORY *Males Only*

Age at first PSA: _____

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? _____

THIS PORTION TO BE COMPLETED BY NURSE ONLY

REVIEW OF SYSTEMS:

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

Pain: Are you experiencing pain? Yes No
 Pain Level: Please rate your pain on a scale of 0-10 (0= no pain, 10 = worst pain): _____

Pain Scale Code/Level

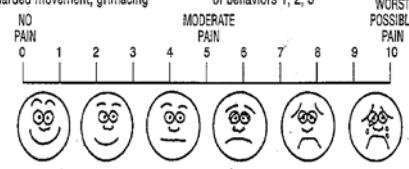
0: Relaxed, calm expression
 1: Stressed, tense expression
 2: Guarded movement, grimacing

3: Moaning, restless
 4: Crying out, increased intensity of behaviors 1, 2, 3

NO PAIN MODERATE PAIN WORST POSSIBLE PAIN

A - Verbal 0-10
 B - Faces 0-10
 C - Non-verbal 0-4

Pain Level _____
 Scale Used _____



Risk to Fall Assessment

Risk to Fall Assessment	Points	Score
Confusion/disorientation/Impulsivity	4	
Symptomatic Depression	2	
Altered Elimination	1	
Dizziness/Vertigo	1	
Gender (Male)	1	
Any administered antiepileptics	2	
Any Administered Benzodiazapines	1	
Get-Up-And-Go Test: Rising from chair		
Ability to rise single movement-No loss of balance with steps	0	
Pushes up – Successful in 1 attempt	1	
Multiple attempts, but successful	3	
Unable to rise without assistance during test or complete bedrest	4	
TOTAL		

Risk to Fall Guidelines implemented if score 5 or greater, including yellow arm band, Yes: NA

Location: _____
 Description: _____
 What makes the pain better? _____
 What makes the pain worse? _____
 Does your pain interfere with your daily functioning? _____
 Other Symptoms Not Listed Above: _____

VITALS: B/P: _____ P: _____ R: _____ T: _____ Wt: _____ Ht: _____ BMI: _____

ASSESSED NEEDS	IDENTIFIED PROBLEMS	REFERRAL ACTIONS TAKEN
Discharge Planning	<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 pt/family <input type="checkbox"/> Patient declines referral <input type="checkbox"/> No needs identified <input type="checkbox"/> MD notified
Functional	<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"/> Patient declines referral <input type="checkbox"/> Arrangements already made <input type="checkbox"/> No needs identified <input type="checkbox"/> MD notified
Nutritional	<input type="checkbox"/> Anorexia <input type="checkbox"/> Obesity	<input type="checkbox"/> Referral given for OP Nutritional Services <input type="checkbox"/> Patient declines referral <input type="checkbox"/> Arrangements already made/family <input type="checkbox"/> No needs identified <input type="checkbox"/> MD notified
Social	<input type="checkbox"/> Suspected abuse/domestic violence/neglect	<input type="checkbox"/> A/N: Referral sent to Case Management/Social Services pt's request <input type="checkbox"/> A/N: Referral to Case Mgmt/Social Services declined <input type="checkbox"/> No needs identified <input type="checkbox"/> MD notified

Nurse Signature _____ Date _____ Time _____
 Physician Signature _____ Date _____ Time _____