PATIENT HEALTH ASSESSMENT

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 “✔” when appropriate. Please bring this completed form with you to your Preadmission Center appointment.

PERSONAL INFORMATION

Patient Name: ____________________________________________

Date of Admission or Procedure: ______________________________

Admitting Physician or Surgeon: ______________________________

Person providing information: ________________________________

Relationship: _____________________________________________ Date: __________________________

Language spoken: □ English □ 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

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: __________________________ Phone # ______________

REASON FOR ADMISSION (please describe):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

ALLERGIES

□ NONE □ MEDICATIONS □ LATEX □ FOOD □ OTHER

List Allergies and Reactions:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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Email the Preadmission Center at patnurse@amh.org
PATIENT HEALTH ASSESSMENT

Current weight ___________  □ Actual  □ Estimated  
*Weight 1 yr. ago ___________  □ Height ___________

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
□ Other __________________________

Immunizations:
□ Tetanus/Yr ________  □ Flu vaccine/Yr ________  □ Pneumonia vaccine/Yr ________
□ Other/Yr __________________________

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

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Dose and Frequency</th>
</tr>
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<tbody>
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</table>

Herbal preparations:

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</tbody>
</table>

Have you had any changes in medication in the past 30 days?  □ YES  □ NO
**PATIENT HEALTH ASSESSMENT**

Patient Name: __________________________

Date of Admission or Procedure: __________________________

<table>
<thead>
<tr>
<th>RESPIRATORY/LUNGS:</th>
<th>□ No problems</th>
<th>□ Sleep apnea</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Asthma</td>
<td>□ Loud snoring</td>
<td>□ Tracheotomy</td>
</tr>
<tr>
<td>□ Cancer</td>
<td>□ Pneumonia</td>
<td>□ TB</td>
</tr>
<tr>
<td>□ Chronic bronchitis</td>
<td>□ Positive TB test</td>
<td></td>
</tr>
<tr>
<td>□ Chronic cough/cough with mucus</td>
<td>□ Recent cold or flu</td>
<td>□ Wheezing</td>
</tr>
<tr>
<td>□ Emphysema</td>
<td>□ Shortness of breath</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VASCULAR/HEART:</th>
<th>□ No problems</th>
<th>□ Palpitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Abnormal EKG</td>
<td>□ Heart attack</td>
<td>□ Phlebitis</td>
</tr>
<tr>
<td>□ Blood clots</td>
<td>□ Heart blockage</td>
<td></td>
</tr>
<tr>
<td>□ Cancer</td>
<td>□ Heart murmur</td>
<td>□ Swelling of feet/ankles/legs</td>
</tr>
<tr>
<td>□ Chest pain</td>
<td>□ High/Low blood pressure</td>
<td>□ Valve disorder</td>
</tr>
<tr>
<td>□ Chest Pressure</td>
<td>□ Internal defibrillator</td>
<td>□ Varicose veins</td>
</tr>
<tr>
<td>□ Circulation problems</td>
<td>□ Irregular heart beat</td>
<td></td>
</tr>
<tr>
<td>□ Fainting episodes</td>
<td>□ Pacemaker</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NEUROLOGICAL/BRAIN/SPINAL CORD:</th>
<th>□ No problems</th>
<th>□ Seizures</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Alzheimers</td>
<td>□ Fainting</td>
<td>□ Paralysis of arm/leg L R</td>
</tr>
<tr>
<td>□ Back pain</td>
<td>□ Frequent headache</td>
<td>□ Tingling of arm/leg L R</td>
</tr>
<tr>
<td>□ Cancer</td>
<td>□ Memory problems</td>
<td>□ Weakness</td>
</tr>
<tr>
<td>□ Difficulty learning</td>
<td>□ Mini stroke</td>
<td></td>
</tr>
<tr>
<td>□ Difficulty speaking</td>
<td>□ Neck pain</td>
<td></td>
</tr>
<tr>
<td>□ Difficulty with balance</td>
<td>□ Numbness</td>
<td></td>
</tr>
<tr>
<td>□ Dizziness</td>
<td>□ Paralysis of arm/leg L R</td>
<td></td>
</tr>
</tbody>
</table>
### Gastrointestinal/Bowel/Digestive

- Bowel obstruction
- Cancer
- Chronic diarrhea
- Cirrhosis of liver
- Colitis
- Colostomy
- Constipation
- Crohn’s disease
- Excessive burping
- Heartburn
- Hemorrhoids
- Hepatitis
- Hiatal hernia
- Iliostomy
- Irritable bowel
- Jaundice
- Pancreatitis
- Rectal bleeding
- Nausea/vomiting
- Ulcer

### Musculoskeletal

- Arthritis
- Artificial joint(s)
- Cancer
- Fracture
- Gout
- Lupus
- Muscle disease
- Muscle weakness
- Osteoporosis
- Pins, Rods, Internal Fixators
- Sciatica
- TMJ pain or jaw disorder

### Endocrine

- Cancer
- Diabetes
- Low blood sugar
- Thyroid disorder
- Anemia
- Blood transfusion
- Cancer
- Easy bruising
- Frequent nosebleeds
- Immunosuppressed

### Blood

- Anemia
- Cancer
- Easy bruising
- Frequent nosebleeds
- Immunosuppressed

### Psychiatric

- Anger
- Anxiety
- Dementia
- Depression
- Eating disorder
- Hallucinations
- Manic depression
- Mood swings
- Schizophrenia
- Suicide attempt
- ________________
**PATIENT HEALTH ASSESSMENT**

**Abington Memorial Hospital**

Patient Name: ____________________________________________

Date of Admission or Procedure: _____________________________

<table>
<thead>
<tr>
<th><strong>SKIN:</strong></th>
<th>□ No problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Bed sore</td>
<td>☐ Shingles</td>
</tr>
<tr>
<td>☐ Non-healing sores</td>
<td>☐ Skin Cancer</td>
</tr>
<tr>
<td>☐ Rashes</td>
<td>☐ Skin disorder</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>URINARY/REPRODUCTIVE:</strong></th>
<th>□ No problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Blood in urine</td>
<td>☐ Loss of control</td>
</tr>
<tr>
<td>☐ Burning</td>
<td>☐ Pain</td>
</tr>
<tr>
<td>☐ Cancer ________________</td>
<td>☐ Prostate Problems (males)</td>
</tr>
<tr>
<td>☐ Difficult urination</td>
<td>☐ Self Catheterization</td>
</tr>
<tr>
<td>☐ Frequent urination</td>
<td>☐ Sexually transmitted diseases</td>
</tr>
<tr>
<td>☐ Infections</td>
<td>☐ Urinary catheter (presently)</td>
</tr>
<tr>
<td>☐ Kidney stones</td>
<td>☐ Ureterostomy</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th><strong>EYES/EARS/NOSE/THROAT:</strong></th>
<th>□ No problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Blind</td>
<td>☐ Deaf</td>
</tr>
<tr>
<td>☐ Cancer ________________</td>
<td>☐ Deviated septum</td>
</tr>
<tr>
<td>☐ Cataracts</td>
<td>☐ Glasses</td>
</tr>
<tr>
<td>☐ Contact lenses</td>
<td>☐ Glaucoma</td>
</tr>
<tr>
<td>☐ Corneal Implants</td>
<td>☐ Hearing aids</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th><strong>OPERATION PROCEDURES:</strong></th>
<th>☐ None</th>
</tr>
</thead>
<tbody>
<tr>
<td>List all surgeries and approximate dates:</td>
<td></td>
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Email the Preadmission Center at patnurse@amh.org
**ANESTHESIA:**  
☐ No problems

- ☐ Never had anesthesia
- ☐ You or a blood relative had unexplained fever right after surgery
- ☐ 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
- ☐ Bridges
- ☐ Dentures:
  - ☐ Upper:
  - ☐ Lower:
- ☐ Broken teeth
- ☐ Caps
- ☐ Implants
- ☐ Loose teeth
- ☐ Full
- ☐ Partial

**NUTRITION:**  
☐ No problems

- ☐ 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)
  - ☐ >15 lbs (4 points)
  - ☐ 6-10 lbs (2 points)
  - ☐ Unsure (2 points)
  - ☐ 11-15 lbs (3 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
<table>
<thead>
<tr>
<th>DISCHARGE/DISPOSITION:</th>
<th>SELF CARE:</th>
<th>□ No problems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Living Arrangements – Patient lives in:</strong></td>
<td><strong>Needs help with:</strong></td>
<td></td>
</tr>
<tr>
<td>□ Apartment</td>
<td>□ Bathing</td>
<td></td>
</tr>
<tr>
<td>□ House</td>
<td>□ Cooking</td>
<td></td>
</tr>
<tr>
<td>□ Personal care facility</td>
<td>□ Dressing</td>
<td></td>
</tr>
<tr>
<td>□ Skilled nursing facility</td>
<td>□ Eating</td>
<td></td>
</tr>
<tr>
<td>□ Long term care facility</td>
<td>□ Homemaking</td>
<td></td>
</tr>
<tr>
<td>□ _____________________________</td>
<td>□ Toileting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ _____________________________</td>
<td></td>
</tr>
<tr>
<td><strong>Patient lives with:</strong></td>
<td><strong>Place patient is planning to go at discharge:</strong></td>
<td></td>
</tr>
<tr>
<td>□ Alone</td>
<td>□ Home</td>
<td></td>
</tr>
<tr>
<td>□ Adult Child</td>
<td>□ Unknown</td>
<td></td>
</tr>
<tr>
<td>□ Parent</td>
<td>□ Preadmission Residence</td>
<td></td>
</tr>
<tr>
<td>□ Private aide</td>
<td>□ _____________________________</td>
<td></td>
</tr>
<tr>
<td>Name of Person:</td>
<td></td>
<td></td>
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<tr>
<td>_____________________________</td>
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<tr>
<td>Phone # _____________________________</td>
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<tr>
<td><strong>Support available at home:</strong></td>
<td><strong>Has 24-hour companion at home:</strong></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>□ Full-time</td>
<td>□ Family</td>
<td></td>
</tr>
<tr>
<td>□ Part-time</td>
<td>□ Spouse</td>
<td></td>
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<tr>
<td>□ Undetermined</td>
<td>□ Friend</td>
<td></td>
</tr>
<tr>
<td>□ No help available</td>
<td>□ Attendant (private aide)</td>
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<td></td>
<td>□ _____________________________</td>
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</tbody>
</table>
PATIENT HEALTH ASSESSMENT

Abington Memorial Hospital

Patient Name: __________________________

Date of Admission or Procedure: __________________________

CURRENT HOME CARE SERVICES/EQUIPMENT:  □ Not applicable

☐ Day Care  ☐ Nursing Care  ☐ Physical Therapy  ☐ Speech Therapy

☐ Hospice  ☐ Occupational Therapy  ☐ Social Worker  ☐ __________________________

Name of Agency: __________________________

Patient Uses:

☐ Cane  ☐ Hospital bed  ☐ Wheelchair

☐ Commode  ☐ Oxygen Therapy  Name of company: __________________________

☐ Grab bar  ☐ Tub bench

MOBILITY/ACTIVITY:

☐ 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:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________