PATIENT HEALTH ASSESSMENT

Abington Memorial Hospital

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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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

Name of medication	**Dose and Frequency**
Herbal preparations:	

Have you had any changes in medication in the past 30 days? ☐ YES ☐ NO

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RESPIRATORY/LUNGS: ☐ No problems

- ☐ Asthma
- ☐ Cancer _____
- ☐ Chronic bronchitis
- ☐ Chronic cough/cough with mucus
- ☐ Emphysema
- ☐ Loud snoring
- ☐ Pneumonia
- ☐ Positive TB test
- ☐ Recent cold or flu
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ TB
- ☐ Tracheotomy
- ☐ Wheezing
- ☐ _____

VASCULAR/HEART: ☐ No problems

- ☐ Abnormal EKG
- ☐ Blood clots
- ☐ Cancer _____
- ☐ Chest pain
- ☐ Chest Pressure
- ☐ Circulation problems
- ☐ Fainting episodes
- ☐ Heart attack
- ☐ Heart blockage
- ☐ Heart murmur
- ☐ High/Low blood pressure
- ☐ Internal defibrillator
- ☐ Irregular heart beat
- ☐ Pacemaker
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swelling of feet/ankles/legs
- ☐ Valve disorder
- ☐ Varicose veins
- ☐ _____

NEUROLOGICAL/BRAIN/ SPINAL CORD: ☐ No problems

- ☐ Alzheimers
- ☐ Back pain
- ☐ Cancer _____
- ☐ Difficulty learning
- ☐ Difficulty speaking
- ☐ Difficulty with balance
- ☐ Dizziness
- ☐ Fainting
- ☐ Frequent headache
- ☐ Memory problems
- ☐ Mini stroke
- ☐ Neck pain
- ☐ Numbness
- ☐ Paralysis of arm/leg L R
- ☐ Seizures
- ☐ Severe headaches
- ☐ Speech slurred
- ☐ Stroke
- ☐ Tingling of arm/leg L R
- ☐ Weakness
- ☐ _____

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GASTROINTESTINAL/BOWEL/DIGESTIVE: ☐ No problems

- ☐ 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
- ☐ _____

MUSKULOSKELETAL: ☐ No problems

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

ENDOCRINE: ☐ No problems

- ☐ Cancer _____
- ☐ Diabetes
- ☐ Hormone disorder
- ☐ Low blood sugar
- ☐ Thyroid disorder
- ☐ _____

BLOOD: ☐ No problems

- ☐ Anemia
- ☐ Blood transfusion
- ☐ Cancer _____
- ☐ Easy bruising
- ☐ Frequent nosebleeds
- ☐ Immunosuppressed
- ☐ _____

PSYCHIATRIC: ☐ No problems

- ☐ Anger
- ☐ Anxiety
- ☐ Dementia
- ☐ Depression
- ☐ Eating disorder
- ☐ Hallucinations
- ☐ Manic depression
- ☐ Mood swings
- ☐ Schizophrenia
- ☐ Suicide attempt
- ☐ _____

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SKIN: ☐ No problems

☐ Bed sore ☐ Shingles ☐ Ulcerations

☐ Non-healing sores ☐ Skin Cancer ☐ _____

☐ Rashes ☐ Skin disorder

URINARY/REPRODUCTIVE: ☐ No problems

☐ Blood in urine ☐ Loss of control

☐ Burning ☐ Pain

☐ Cancer _____ ☐ Prostate Problems (males)

☐ Difficult urination ☐ Self Catheterization

☐ Frequent urination ☐ Sexually transmitted diseases

☐ Infections ☐ Urinary catheter (presently)

☐ Kidney stones ☐ Ureterostomy

☐ _____

Females:

Last menstrual period: _____

Pregnant:

☐ Yes ☐ No ☐ Unsure

Weeks pregnant: _____

Due date: _____

☐ Breast feeding

EYES/EARS/NOSE/THROAT: ☐ No problems

☐ Blind ☐ Deaf ☐ Hearing impairment

☐ Cancer _____ ☐ Deviated septum ☐ Ringing in ears

☐ Cataracts ☐ Glasses ☐ Sinus problems

☐ Contact lenses ☐ Glaucoma ☐ TTY needed

☐ Corneal Implants ☐ Hearing aids ☐ _____

OPERATION PROCEDURES: ☐ None

List all surgeries and approximate dates:

_____

_____

_____

_____

_____

_____

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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
- ☐ Broken teeth
- ☐ Caps
- ☐ Implants
- ☐ Loose teeth
- ☐ _____
- ☐ **Dentures:**
- ☐ Upper:
  - ☐ *Full* ☐ *Partial*
- ☐ Lower:
  - ☐ *Full* ☐ *Partial*

NUTRITION: ☐ No problems

Special Diet: ☐ 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)
- ☐ 6-10 lbs (2 points)
- ☐ 11-15 lbs (3 points)
- ☐ >15 lbs (4 points)
- ☐ Unsure (2 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

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DISCHARGE/DISPOSITION:

Living Arrangements – Patient lives in:

☐ Apartment
☐ House
☐ Personal care facility
☐ Skilled nursing facility
☐ Long term care facility
☐ _____

Patient lives with:

☐ Alone ☐ Sibling
☐ Adult Child ☐ Spouse
☐ Parent ☐ Friend/Other
☐ Private aide

Name of Person:

_____

Phone # _____

Support available at home:

☐ Full-time
☐ Part-time
☐ Undetermined
☐ No help available

SELF CARE: ☐ No problems

Needs help with:

☐ Bathing
☐ Cooking
☐ Dressing
☐ Eating
☐ Homemaking
☐ Toileting
☐ _____

Place patient is planning to go at discharge:

☐ Home ☐ Unknown
☐ Preadmission Residence
☐ _____

Person Responsible for transportation home:

Name of Person:

_____

Phone # _____

Has 24-hour companion at home: ☐ Yes ☐ No

☐ Family ☐ Spouse
☐ Friend ☐ Attendant (private aide)
☐ _____

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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:

☐ Minimal

☐ Moderate

☐ Maximum

☐ Patient is bed bound

Assistive Devices Used:

☐ Cane ☐ Walker

☐ Crutches ☐ Wheeled walker

☐ Hemicane ☐ Wheelchair

☐ _____

Prosthetic device:

_____

_____

_____

_____

Communications level/Devices:

☐ Normal ☐ Impaired

Please state anything else you think we should know:

_____

_____

_____

_____

_____

_____

_____