Memorial Hermann Specialty Hospital Kingwood

P.A.T. Admission Data - Page 1 of 2

Name:

DOB: (MM/DD/YYYY)

What **HEALTH PROBLEMS** brought you to the hospital?

List **SURGERIES** you have had:

Who is your primary medical doctor/who prescribes your medications?

Who is your Cardiologist/Heart Specialist?

PAST MEDICAL HISTORY

Do you have a **PERSONAL HISTORY** of:

Stroke/TIA	☐ Yes	☐ No
Seizures, unconsciousness, convulsions	☐ Yes	☐ No
Problems with your teeth or gums	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No
CPAP	☐ Yes	☐ No
Home oxygen	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Coronary artery disease	☐ Yes	☐ No
Arrhythmias	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Do you have a cardiologist?	☐ Yes	☐ No
When was your last EKG? Where:		
Cancer	☐ Yes	☐ No
Location: When:		
Treated	☐ Yes	☐ No
Remission	☐ Yes	☐ No
Liver disease/Hepatitis	☐ Yes	☐ No
Kidney/Bladder disease	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Bladder infections	☐ Yes	☐ No
Reflux	☐ Yes	☐ No
Hiatal hernia	☐ Yes	☐ No
Peptic ulcer disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Insulin dependent	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Regulated with medications	☐ Yes	☐ No
Dizziness or slipping easily	☐ Yes	☐ No
Depression or Mental illness	☐ Yes	☐ No
HIV/Sexually transmitted disease	☐ Yes	☐ No
History of drug reactions	☐ Yes	☐ No
Broken facial bones, jaw or nose surgery	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Back or neck trouble	☐ Yes	☐ No
Problems with anesthesia	☐ Yes	☐ No
Thyroid or goiter problems	☐ Yes	☐ No
Blood transfusions	☐ Yes	☐ No
Unusual muscle weakness in arms/legs	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Abnormal chest film or abnormal EKG	☐ Yes	☐ No
Mononucleosis within one year	☐ Yes	☐ No
Sickle Cell disease/trait	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No
Serious illness in the past	☐ Yes	☐ No
Recent exposure to any contagious disease	☐ Yes	☐ No
Do you currently have an upper respiratory infection or cold?	☐ Yes	☐ No

If YES, what symptoms:

How long?

Has anyone in your **FAMILY** had problems with anesthesia? ☐ Yes ☐ No

If YES, explain:

TB SCREENING

Have you experienced any of the following:

Cough for greater than 3 weeks	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Positive test or treatment for TB	☐ Yes	☐ No
Within the past year, have you been in close contact with anyone who has TUBERCULOSIS?	☐ Yes	☐ No

If you answered "yes" to two or more of the above questions, see the nurse immediately. Airborne isolation precautions may need to be implemented. Your physician and infection control will need to be contacted for follow-up.

TOBACCO / ALCOHOL / DRUGS

Do you use **TOBACCO** products?	☐ Yes	☐ No
Cigarettes	☐ Yes	☐ No
Cigars	☐ Yes	☐ No
Pipe	☐ Yes	☐ No
Chewing tobacco	☐ Yes	☐ No

If YES, please list amount and frequency:

Do you drink **ALCOHOL**? ☐ Yes ☐ No

If YES, please list amount and frequency:

If YES, please check if any of the following apply:

- ☐ You have felt that you should cut down on your drinking
- ☐ You have felt bad or guilty about drinking
- ☐ You have had a drink (eye opener) first thing in the morning to steady your nerves or get rid of a hangover
- ☐ You have had seizures, hallucinations, or required hospitalization when you stopped drinking
- ☐ Someone has annoyed you by criticizing your drinking

In the past 6 months, have you used:
STREET or **RECREATIONAL DRUGS**? ☐ Yes ☐ No

If YES, please list type, amount and frequency:

Have you ever had **TREATMENT** for **DRUG** or **ALCOHOL ABUSE**? ☐ Yes ☐ No

If YES, please list date & duration of treatment:

PREGNANCIES

Are you **PREGNANT**? ☐ Yes ☐ No

Date of last menstrual period:

Normal ☐ Yes ☐ No

If NO, describe (heavy, long durations, painful, etc.):

Number of: Pregnancies: Live births:
Abortions: Miscarriages:

ADVANCE DIRECTIVES

Do you have and **ADVANCE DIRECTIVE**?	☐ Yes	☐ No
Living Will	☐ Yes	☐ No
Power of Attorney	☐ Yes	☐ No
Durable	☐ Yes	☐ No
Medical	☐ Yes	☐ No

If you have a P.O.A., who is your clinical decision maker?

Relationship to you:

Home Phone: Cell Phone:

Work Phone: Pager:

Are they with you today? ☐ Yes ☐ No

Do you want information on Advance Directives? ☐ Yes ☐ No

MEDICATIONS

What **CURRENT MEDICATIONS** or **HERBAL REMEDIES** do you take?

MEDICATION	DOSAGE	ROUTE	FREQUENCY

Do you have a pacemaker or implanted cardioverter or defibrillator? ☐ Yes ☐ No *If YES, date implanted:*

Do you have an implanted vascular access? ☐ Yes ☐ No Type:

Purpose: Location:

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NUTRITION / GI STATUS

Are you on a **SPECIAL DIET**? ☐ Yes ☐ No
If YES, please describe:
Do you have any **NEW** problems with:
- Chewing ☐ Yes ☐ No
- Swallowing ☐ Yes ☐ No
- Feeding yourself ☐ Yes ☐ No
- Selecting your menu ☐ Yes ☐ No

Have you noticed any unintentional **CHANGES IN YOUR WEIGHT** in the last 3 months? ☐ Yes ☐ No
If YES, what is your normal weight?
Do you have problems with:
- Urination ☐ Yes ☐ No
- Constipation ☐ Yes ☐ No
- Diarrhea ☐ Yes ☐ No
- Bleeding ☐ Yes ☐ No

If YES, please explain:
Do you have a **COLOSTOMY or UROSTOMY**? ☐ Yes ☐ No
How often do you have bowel movements?
Have you had any CHANGE IN YOUR BOWEL HABITS in the last 3 months? ☐ Yes ☐ No
If YES, please explain:

SLEEP

Do you have any **DIFFICULTY SLEEPING**? ☐ Yes ☐ No
Do you require medication to help sleep? ☐ Yes ☐ No
If YES, what & how often?
How many hours do you sleep at night?
How many naps do you take per day?

FUNCTIONAL / FALL RISKS

Do you **NEED HELP WITH**:
- Getting in or out of a bed or chair ☐ Yes ☐ No
- Standing ☐ Yes ☐ No
- Walking ☐ Yes ☐ No
- Climbing stairs ☐ Yes ☐ No
- Bathing ☐ Yes ☐ No
- Dressing ☐ Yes ☐ No
- Reading ☐ Yes ☐ No

If any of these are YES, is the a NEW problem? ☐ Yes ☐ No

Do you use:
- A Cane ☐ Yes ☐ No
- A Walker ☐ Yes ☐ No
- A Wheelchair ☐ Yes ☐ No
- Glasses/Contact lenses ☐ Yes ☐ No
- Hearing aid(s) ☐ Yes ☐ No
- Dentures ☐ Yes ☐ No

Other assistive devices:

Have you had a recent problem with:
- Slipping ☐ Yes ☐ No
- Falling ☐ Yes ☐ No
- Feeling unsteady ☐ Yes ☐ No
- Being dizzy ☐ Yes ☐ No

PAIN HISTORY

Have you had any **RECENT PAIN**? ☐ Yes ☐ No
If YES, please answer the following questions:
Location:
Quality (sharp, dull, knife-like, etc.):
Onset (when it started):
How long does it last?
Variations:
What makes it worse?
What makes it better?
What are you using to manage the pain?

How is it working?
How has the pain affected your life?
What level of pain relief would you consider to be adequate for you?

Please rate your **CURRENT PAIN**: 0 1 2 3 4 5 6 7 8 9 10 (NO PAIN — WORST PAIN EVER)

Rate your **AVERAGE DAILY PAIN**: 0 1 2 3 4 5 6 7 8 9 10 (NO PAIN — WORST PAIN EVER)

DEVELOPMENTAL STAGE

(Please check all that apply in appropriate age row)

Age				
Neonate	☐ Equal movements	☐ Palmer grasp	☐ Lifts head	
2-14 months	☐ Social smile	☐ Coos	☐ Grasps object	☐ Raises head 45°
4-6 months	☐ Laughs	☐ Turns to sound	☐ Rolls front/back	☐ Reaches
6-9 months	☐ Babbles	☐ Sits with support	☐ Passes hand to hand	☐ Crawls/creeps
9-12 months	☐ Imitates sounds	☐ Plays games	☐ Pulls to stand	☐ Bangs 2 cubes
12-15 months	☐ Understand simple commands		☐ 3-6 words	☐ Walks alone
15-18 months	☐ Uses spoon	☐ 4-10 words	☐ Walks backwards	☐ Scribbles
2 years	☐ 50+ words	☐ Knows name	☐ Runs	☐ Stacks blocks
3 years	☐ Knows age	☐ Feeds self	☐ Dresses self	☐ Counts to 3
4 years	☐ Gender ID	☐ Plays with imaginary friend	☐ Hops	☐ Cut and paste
School age	☐ School	☐ Can tell time	☐ Enjoys reading	☐ In present
Adolescence	☐ Awkward in gross motor activity		☐ Abstract reasoning	☐ Competition
Early adult	☐ Reasoning, creative imagination peaks		☐ Achievement oriented	☐ Initiating career
Middle adult	☐ Slowing of reflexes	☐ Future oriented	☐ Working way up career ladder	
Late adult	☐ Decrease in memory	☐ Health concern	☐ Retirement	☐ Shares wisdom

CHILDREN

IF PATIENT IS 6 YEARS OR YOUNGER
- Breath holding spells ☐ Yes ☐ No
- History of prematurity ☐ Yes ☐ No
  - *If YES, was oxygen used?* ☐ Yes ☐ No
  - *Any lasting effects?* ☐ Yes ☐ No

PSYCHOSOCIAL

Do you have somewhere to live? ☐ Yes ☐ No Do you have running water? ☐ Yes ☐ No Do you have electricity? ☐ Yes ☐ No
Are you responsible for caring for anyone else? ☐ Yes ☐ No *If YES, who?*
Where do you plan to go after you are discharged from the hospital?
Who will take you there? Who will help with your care when you leave the hospital?
Did any agencies or people help with your care before you came to the hospital? ☐ Yes ☐ No *If YES, who?*
What help did they give you?
What are your major sources of EMOTIONAL SUPPORT?
Is RELIGION important to you? ☐ Yes ☐ No *If YES, what religion are you?*

Do you anticipate any of these problems after you leave the hospital?
- ☐ Keeping Dr. appointments
- ☐ Getting or paying for medicines
- ☐ Obtaining meals
- ☐ Paying your medical bills
- ☐ Caring for yourself
- ☐ Caring for someone else
- ☐ Following discharge instruction

If YES, to any of these, please describe the problem(s) you anticipate:

Are you in a relationship with someone who is hurting you physically or verbally? ☐ Yes ☐ No
Within the last year has anyone forced you to engage in sexual relations against your will? ☐ Yes ☐ No
Within the last year has anyone hit, slapped, or beaten you? ☐ Yes ☐ No

Do you have and RELIGIOUS or CULTURAL TRADITIONS we need to know about? ☐ Yes ☐ No
If YES, please explain:

Information provided by:
Relationship to patient:

Reviewed by: ______________________
R.N. Signature