

Memorial Hermann Specialty Hospital Kingwood

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

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

Name: _____

DOB: (MM/DD/YYYY) _____

TB SCREENING	Have you experienced any of the following:		
	Cough for greater than 3 weeks	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Night sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Coughing up blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Positive test or treatment for TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Within the past year, have you been in close contact with anyone who has TUBERCULOSIS?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<i>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.</i>		

TOBACCO / ALCOHOL / DRUGS	Do you use TOBACCO products?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Cigarettes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Cigars	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Pipe	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Chewing tobacco	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<i>If YES, please list amount and frequency:</i>		
	Do you drink ALCOHOL ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<i>If YES, please list amount and frequency:</i>		
	<i>If YES, please check if any of the following apply:</i>		
	<input type="checkbox"/> You have felt that you should cut down on your drinking		
<input type="checkbox"/> You have felt bad or guilty about drinking			
<input type="checkbox"/> You have had a drink (eye opener) first thing in the morning to steady your nerves or get rid of a hangover			
<input type="checkbox"/> You have had seizures, hallucinations, or required hospitalization when you stopped drinking			
<input type="checkbox"/> Someone has annoyed you by criticizing your drinking			
<i>In the past 6 months, have you used:</i>			
STREET or RECREATIONAL DRUGS?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<i>If YES, please list type, amount and frequency:</i>			
Have you ever had TREATMENT for DRUG or ALCOHOL ABUSE ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<i>If YES, please list date & duration of treatment:</i>			

PREGNANCIES	Are you PREGNANT ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Date of last menstrual period:		
	Normal	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If NO, describe (heavy, long durations, painful, etc.):</i>			
Number of: Pregnancies:		Live births:	
Abortions:		Miscarriages:	

ADVANCE DIRECTIVES	Do you have and ADVANCE DIRECTIVE ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Living Will	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Power of Attorney	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Durable	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Medical	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you want information on Advance Directives?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

MEDICATIONS	What CURRENT MEDICATIONS or HERBAL REMEDIES do you take?				
	MEDICATION	DOSE	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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Name: _____

DOB: (MM/DD/YYYY) _____

NUTRITION / GI STATUS	Are you on a SPECIAL DIET ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If YES, please describe:</i>
	Do you have any NEW problems with:
	Chewing <input type="checkbox"/> Yes <input type="checkbox"/> No
	Swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No
	Feeding yourself <input type="checkbox"/> Yes <input type="checkbox"/> No
	Selecting your menu <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you noticed any unintentional CHANGES IN YOUR WEIGHT in the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If YES, what is your normal weight?</i>
	Do you have problems with:
	Urination <input type="checkbox"/> Yes <input type="checkbox"/> No
	Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If YES, please explain:</i>	
Do you have a COLOSTOMY or UROSTOMY ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How often do you have bowel movements?	
Have you had any CHANGE IN YOUR BOWEL HABITS in the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If YES, please explain:</i>	

SLEEP	Do you have any DIFFICULTY SLEEPING ? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you require medication to help sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If YES, what & how often?</i>
	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 <input type="checkbox"/> Yes <input type="checkbox"/> No
	Standing <input type="checkbox"/> Yes <input type="checkbox"/> No
	Walking <input type="checkbox"/> Yes <input type="checkbox"/> No
	Climbing stairs <input type="checkbox"/> Yes <input type="checkbox"/> No
	Bathing <input type="checkbox"/> Yes <input type="checkbox"/> No
	Dressing <input type="checkbox"/> Yes <input type="checkbox"/> No
	Reading <input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>If any of these are YES, is the a NEW problem?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you use:
	A Cane <input type="checkbox"/> Yes <input type="checkbox"/> No
	A Walker <input type="checkbox"/> Yes <input type="checkbox"/> No
	A Wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No
	Glasses/Contact lenses <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hearing aid(s) <input type="checkbox"/> Yes <input type="checkbox"/> No
Dentures <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other assistive devices:	
Have you had a recent problem with:	
Slipping <input type="checkbox"/> Yes <input type="checkbox"/> No	
Falling <input type="checkbox"/> Yes <input type="checkbox"/> No	
Feeling unsteady <input type="checkbox"/> Yes <input type="checkbox"/> No	
Being dizzy <input type="checkbox"/> Yes <input type="checkbox"/> No	

PAIN HISTORY	Have you had any RECENT PAIN ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If YES, please answer the following questions:</i>
	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)				
	Neonate	<input type="checkbox"/> Equal movements	<input type="checkbox"/> Palmer grasp	<input type="checkbox"/> Lifts head	
	2-14 months	<input type="checkbox"/> Social smile	<input type="checkbox"/> Coos	<input type="checkbox"/> Grasps object	<input type="checkbox"/> Raises head 45°
	4-6 months	<input type="checkbox"/> Laughs	<input type="checkbox"/> Turns to sound	<input type="checkbox"/> Rolls front/back	<input type="checkbox"/> Reaches
	6-9 months	<input type="checkbox"/> Babbles	<input type="checkbox"/> Sits with support	<input type="checkbox"/> Passes hand to hand	<input type="checkbox"/> Crawls/creeps
	9-12 months	<input type="checkbox"/> Imitates sounds	<input type="checkbox"/> Plays games	<input type="checkbox"/> Pulls to stand	<input type="checkbox"/> Bangs 2 cubes
	12-15 months	<input type="checkbox"/> Understand simple commands	<input type="checkbox"/> 3-6 words	<input type="checkbox"/> Walks alone	
	15-18 months	<input type="checkbox"/> Uses spoon	<input type="checkbox"/> 4-10 words	<input type="checkbox"/> Walks backwards	<input type="checkbox"/> Scribbles
	2 years	<input type="checkbox"/> 50+ words	<input type="checkbox"/> Knows name	<input type="checkbox"/> Runs	<input type="checkbox"/> Stacks blocks
	3 years	<input type="checkbox"/> Knows age	<input type="checkbox"/> Feeds self	<input type="checkbox"/> Dresses self	<input type="checkbox"/> Counts to 3
	4 years	<input type="checkbox"/> Gender ID	<input type="checkbox"/> Plays with imaginary friend	<input type="checkbox"/> Hops	<input type="checkbox"/> Cut and paste
	School age	<input type="checkbox"/> School	<input type="checkbox"/> Can tell time	<input type="checkbox"/> Enjoys reading	<input type="checkbox"/> In present
	Adolescence	<input type="checkbox"/> Awkward in gross motor activity	<input type="checkbox"/> Abstract reasoning	<input type="checkbox"/> Competition	
Early adult	<input type="checkbox"/> Reasoning, creative imagination peaks	<input type="checkbox"/> Achievement oriented	<input type="checkbox"/> Initiating career		
Middle adult	<input type="checkbox"/> Slowing of reflexes	<input type="checkbox"/> Future oriented	<input type="checkbox"/> Working way up career ladder		
Late adult	<input type="checkbox"/> Decrease in memory	<input type="checkbox"/> Health concern	<input type="checkbox"/> Retirement	<input type="checkbox"/> Shares wisdom	

CHILDREN	IF PATIENT IS 6 YEARS OR YOUNGER
	Breath holding spells <input type="checkbox"/> Yes <input type="checkbox"/> No
	History of prematurity <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If YES, was oxygen used?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>Any lasting effects?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No

PSYCHOSOCIAL	Do you have somewhere to live? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have running water? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have electricity? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are you responsible for caring for anyone else? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If YES, who?</i>			
	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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If YES, who?</i>			
	What help did they give you?			
	What are your major sources of EMOTIONAL SUPPORT?			
	Is RELIGION important to you? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If YES, what religion are you?</i>			
	Do you anticipate any of these problems after you leave the hospital?			
	<input type="checkbox"/> Keeping Dr. appointments	<input type="checkbox"/> Paying your medical bills	<input type="checkbox"/> Following discharge instruction	
<input type="checkbox"/> Getting or paying for medicines	<input type="checkbox"/> Caring for yourself	<i>If YES, to any of these, please describe the problem(s) you anticipate:</i>		
<input type="checkbox"/> Obtaining meals	<input type="checkbox"/> Caring for someone else			
Are you in a relationship with someone who is hurting you physically or verbally? <input type="checkbox"/> Yes <input type="checkbox"/> No	Within the last year has anyone forced you to engage in sexual relations against your will? <input type="checkbox"/> Yes <input type="checkbox"/> No	Within the last year has anyone hit, slapped, or beaten you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have and RELIGIOUS or CULTURAL TRADITIONS we need to know about? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If YES, please explain:</i>				

Information provided by:

Relationship to patient:

Reviewed by: _____

R.N. Signature