PATIENT DATA BASE

SECTION I **Please complete this form concerning your health. The information you provide will be used as a basis for planning your care.**

1. What problem(s) brought you to the hospital? _____

2. What do you know about your problem(s)? _____

3. What are you most concered about right now? _____

4. What significant health problems have you had? _____

5. Have you ever been hospitalized before? ☐ No ☐ Yes Date _____

6. For what problems have you been hospitalized? _____

7. List drugs/medical you are taking:

Drug	Date/Time Last Taken	Drug	Date/Time Last Taken

8. Do you have allergies to any of the following? If so, please list.

medicines:	No ☐	Yes ☐	_____
foods:	No ☐	Yes ☐	_____
adhesive tape:	No ☐	Yes ☐	_____
other	No ☐	Yes ☐	_____

9. List the kinds of allergic reactions you have to the items above. _____

10. Do you have any special dietary requirements/restrictions?
No ☐ Yes ☐ (please explain) _____

ADDRESSOGRAPH

11. What are your usual patterns of living concerning; describe

sleeping _____

smoking _____

alcohol intake _____

bowel elimination _____

urine elimination _____

12. Please check the activities with which you need assistance:

☐ bathing ☐ eating ☐ walking ☐ dressing

Explain: _____

_____

_____

13. I require the following items **I have these items with me**

☐	contact lenses	☐
☐	hearing aid	☐
☐	dentures	☐
☐	prosthetic device	☐
☐	ostomy equipment	☐
☐	wheel chair	☐
☐	walker/cane	☐
☐	glasses	☐

Explain: _____

_____

_____

14. What is your occupation? _____

15. Are you currently employed? _____

16. What is the highest level of education you have completed? _____

Please place a check mark in the box next to each symptom or problem you are having. If you are having no problems, check no difficulty.

Breathing:

☐ NO DIFFICULTY

☐ coughing
☐ wheezing
☐ shortness of breath

☐ difficulty breathing when lying down
☐ pain
☐ other

Explain: _____

_____

_____

Circulation and heart

☐ NO DIFFICULTY

☐ palpitations
☐ dizziness
☐ bruising
☐ chest pain

☐ swelling
☐ headache
☐ fainting
☐ other

Explain: _____

_____

_____

Stomach/bowels:

- ☐ NO DIFFICULTY
- ☐ nausea/vomiting
- ☐ difficulty swallowing
- ☐ indigestion
- ☐ bleeding
- ☐ constipation
- ☐ diarrhea
- ☐ pain
- ☐ change in habits
- ☐ other

Explain: _____

Bladder/kidney:

- ☐ NO DIFFICULTY
- ☐ trouble holding
- ☐ burning
- ☐ bloody urine
- ☐ frequency
- ☐ color change
- ☐ difficulty starting stream
- ☐ pain/pressure
- ☐ other

Explain: _____

Muscles/bones:

- ☐ NO DIFFICULTY
- ☐ cramping
- ☐ aches/pains
- ☐ swelling
- ☐ trouble moving
- ☐ weakness
- ☐ other

Explain: _____

Reproductive:

- ☐ NO DIFFICULTY
- ☐ bleeding
- ☐ discharges
- ☐ change of life problem
- ☐ pain
- ☐ other

Explain: _____

Skin:

- ☐ NO DIFFICULTY
- ☐ sores
- ☐ dryness/cracking
- ☐ excessive moisture
- ☐ rash
- ☐ temperature/color change
- ☐ lumps
- ☐ changes in moles
- ☐ other

Explain: _____

ADDRESSOGRAPH

Nerves:

☐ NO DIFFICULTY

☐ numbness
☐ tingling
☐ tremors
☐ seizures/convulsions

☐ paralysis
☐ poor coordination
☐ forgetfullness
☐ other

Explain: _____

Vision/Hearing/Speech:

☐ NO DIFFICULTY

☐ blurred/double vision
☐ light sensitivity
☐ difficulty seeing
☐ ringing in ears

☐ difficulty hearing
☐ difficulty speaking
☐ voice changes
☐ pain/pressure
☐ other

Explain: _____

Nerves:

☐ NO DIFFICULTY

☐ anxiety/nervousness
☐ tension
☐ restless

☐ depression
☐ irritability
☐ other

Explain: _____

Is there any additional information you would like to give us? _____

Are you currently being assisted by any community services? _____

If you need assistance after you are discharged from the hospital, will there be someone to provide it? _____

Signature of Patient

Signature of person completing form (if other than patient)

SECTION II **(To be completed and signed by a registered nurse)**

NURSING SUMMARY: _____

PATIENT PROBLEMS IDENTIFIED AND LISTED ON CARE PLAN ☐ YES: ☐ NO:

Signature and date