

NEUROLOGICAL (headache, fainting, dizziness, ataxia, blackouts, paralysis, vertigo, numbness, tingling, burning, tremors, memory loss, mood changes, anxiety, speech problems, loss of consciousness, hallucinations, visual disturbances, disorientation, history of brain injury, CVA)

EYES / EARS / NOSE (eyeglasses, contacts, redness, vision problems, ocular discharge, glaucoma, cataracts, eye injuries, nasal discharge, nosebleeds, sinus infections, hay fever, nasal obstruction, frequent colds, hearing aid, hearing loss, deafness, tinnitus, dizziness, ear discharge, vertigo, ear pain)

MOUTH / THROAT (condition of teeth and gums, halitosis, dysphagia, dysphasia, frequent sore throats, change in voice, persistent hoarseness, thyroid problems, goiter, lumps, neck pain, swollen nodes)

BREAST (lumps, discharge, pain, frequency of self-exam) Last mammogram: _____ Family history of BCA: Yes / No

CARDIOVASCULAR (chest pain, palpitations, murmurs, hypertension, hypotension, SOB on exertion or lying down, hx of MI, hx of Rheumatic Fever, varicose veins, pain in legs or calves on ambulation, edema in hands/feet, coolness of extremity, loss of hair on legs, discoloration of extremity, ulcers)

S3 _____ S4 _____ Murmur _____ / _____ On Tele? Y / N Why: _____
Pulse Amplitude / Rhythm - RUE _____ LUE _____ RLE _____ LLE _____

RESPIRATORY (cough, wheezing, sputum amount and color, bloody sputum, SOB, asthma, COPD, TB)

Smoking history - Current PPD _____ Past PPD _____ Pack History _____

GASTROINTESTINAL / GENITOURINARY (recent weight loss, appetite change, heartburn, belching, nausea, vomiting, abdominal pain, constipation, change in color/consistency/frequency of BM, hemorrhoids, rectal bleeding, use of laxatives, jaundice, hepatitis, gallbladder problems, dysuria, polyuria, frequency/urgency, difficulty starting stream, stress incontinence, hematuria, flank pain, nocturia, retention, kidney stones, UTIs)

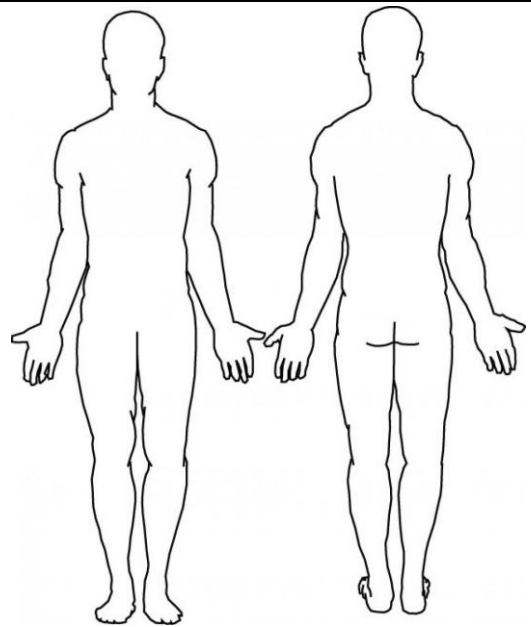
Date of Last BM _____ Appearance _____ Bowel Sounds _____
Catheter _____ Urine Color _____ Odor _____ Consistency _____
Diet (including nutritional supplements) _____

REPRODUCTIVE (Male → Prostate issues, self-exam of testicles, changes in sexual function, infertility, birth control; Female → Onset of menses, frequency and length of periods, date of menopause, pregnancies/miscarriages, irregular periods, fertility issues, birth control)

Date of last PAP smear _____ Contraception used _____

MUSCULOSKELETAL (pain or stiffness in joints, weakness, deformities, gait dysfunction, ambulatory dysfunction, joint clicking, muscle cramps or spasms, use of assistive devices, use of prosthesis, problems with balance, gout, arthritis, bursitis, fractures, ability to carry out ADLs)
Extremity Strength RUE _____ / 5 LUE _____ / 5 RLE _____ / 5 LLE _____ / 5
Therapies ordered PT OT Other: _____

INTEGUMENTARY (rashes, itching, hives, bruising, eczema, dryness, color change, hair texture change, nail texture change, appearance of nails, previous skin disorders, lumps, pressure ulcer (current), pressure ulcer (history))
Braden Score _____ Low Risk / Moderate Risk / High Risk
Precautions _____



PSYCHOSOCIAL

Who do they live with? What kind of structure do they live in?

Can they do stairs? Are there safety risks at home? Do they have a history of falls? Where/why did they fall?

Are they married? Do they have children? Who is their support system? Are they religious?

Do they/have they used community resources (i.e., Meals on Wheels, public transit, homebound services, etc.)?

Do they work? If yes, what do they do? Are they retired? If yes, do they have any hobbies?

Any history of substance or alcohol abuse? If yes, what? How much? Current or past? Showing signs of withdrawal?

What are their usual coping strategies? What are they most concerned about right now?

Barriers to discharge? Plans after discharge? Returning home? Going to ALF/SNF/LTACH/Rehab?