ADULT NURSING ADMISSION HISTORY

DATE	TIME	UNIT	PATIENT'S AGE

HOW DID YOUR PROBLEM PRESENT ITSELF?

HEALTH PERCEPTION / HEALTH MANAGEMENT

HOW IS YOUR GENERAL HEALTH?_____

HEALTH HISTORY

☐CANCER: ☐HTN: ☐HEPATITIS: ☐RENAL:

☐RESPIRATORY: ☐DIABETES: ☐STROKE: ☐MUSCLE/BONE:

☐CARDIAC: ☐GI: ☐SEIZURES: ☐MENTAL HEALTH:

☐RENAL: ☐BLEEDING: ☐GLAUCOMA:

ALCOHOL USE? ☐NO ☐YES: HOW MUCH?_____ HOW LONG?_____

TOBACCO USE? ☐NO ☐YES PACKS/DAY?_____ DO YOU LIVE W/SOMEONE WHO SMOKES? ☐NO ☐YES

RECREATIONAL DRUG USE? ☐DENIES FORMER USE/CURRENT USE ☐YES: DESCRIBE_____

ASSISTIVE CARE: ☐NONE ☐HOUSEKEEPER ☐HOME HEALTH:_____ ☐MEALS ON WHEELS ☐OTHER:_____

LIVING ARRANGEMENTS: ☐ALONE ☐W/SPOUSE/SIGNIFICANT OTHER ☐W/PARENTS ☐CAREGIVER FOR ANOTHER PERSON

☐FROM CARE FACILITY:_____

SURGICAL HISTORY

_____ _____

_____ _____

_____ _____

ANESTHESIA PROBLEMS OR FAMILY HISTORY:

CARE CONCERNS

☐Impaired home maintenance management

☐Altered health maintenance

High risk for:

☐Infection

☐Injury

☐Non-Compliance

☐Altered protection

☐Discharge planning needs

ALLERGIES

☐**No Known Allergies**

ALLERGEN	TYPE OF REACTION	ALLERGEN	TYPE OF REACTION

MEDICATIONS: PRESCRIPTION/ NONPRESCRIPTION/ HERBALS/ VITAMINS

MEDICATION	DOSE	FREQUENCY	LAST DOSE	MEDICATION	DOSE	FREQUENCY	LAST DOSE

HAVE YOU BEEN ABLE TO FOLLOW PRESCRIBED MEDS./TREATMENTS? ☐YES ☐NO - why?_____

FAMILY PHYSICIAN_____ CARDIOLOGIST_____ NEPHROLOGIST_____

SURGEON_____ DIABETOLOGIST_____ OTHER _____

PRIMARY RN_____

Valuables ☐Kept in room ☐Sent home with_____ ☐Sent to cashier by_____

ADULT NURSING ADMISSION ASSESSMENT
2/00

NUTRITIONAL /METABOLIC

1. TYPICAL DAILY FOOD INTAKE_____ Fluid intake_____
2. APPETITE: ☐Good ☐Fair ☐Poor If poor, how long?_____
   Recent changes in appetite or eating patterns: ☐ None ☐Yes - Describe: _____
3. RECENT WEIGHT CHANGES: ☐No ☐Yes, Amt/time_____
4. Food or eating: ☐ Discomfort ☐Difficulty swallowing ☐ Difficulty chewing
   SPECIAL DIET: ☐No ☐Yes , Specify:_____
5. HEALING: Skin lesions heal well ☐Yes ☐ No
   _____
6. RECENT EXPERIENCE WITH FEVER OR CHILLS? ☐No ☐Yes - Describe: _____
7. METHOD AND FREQUENCY OF BLOOD SUGAR MONITORING**:** Frequency:_____
   Meter Type:_____
8. Other Observations_____
   _____

CARE CONCERNS

Nutrition Needs
Fluid Volume/Risk for:
☐ Deficit
☐ Excess
Altered nutrition:
☐ Obesity/risk for
☐ Nut. deficit
☐ Impaired swallowing
☐ Risk for aspiration
Skin Integrity:
☐ High risk
☐ Impaired
☐ Risk For Infection
☐ Altered body temp/risk for

ELIMINATION

1. BLADDER: ☐No Problems ☐Urgency ☐Retention ☐Dribbling ☐Frequency ☐Burning
   ☐ Incontinence ☐ Hematuria ☐ Other_____
2. BOWEL: ☐No Problems ☐Diarrhea ☐Constipation ☐Incontinence ☐Pain ☐Blood in stool
   ☐Hemorrhoids ☐Other_____
   FREQUENCY:_____ LAST BOWEL MOVEMENT_____
   INTERVENTIONS: ☐None ☐Laxatives ☐Enemas ☐Other_____ Frequency_____
3. Other observations:_____ _____

CARE CONCERNS

☐Altered Urinary Elimination (Describe)
☐ Altered Bowel Elimination (Describe)

ACTIVITY/EXERCISE

1. MOBILITY STATUS: ☐Ambulatory ☐Ambulatory W/assist ☐Transfer W/assist ☐Bedrest
2. ASSISTIVE DEVICES: ☐ Cane ☐Walker ☐Crutches ☐Wheelchair ☐Prosthesis (type)_____
   ☐ Other_____ w/patient ☐ Yes ☐ No
3. LIMITATIONS: ☐ None ☐Weakness ☐Fatigue ☐ SOB ☐Dizziness ☐Syncope/fainting
   ☐ Pain Describe:_____ ☐ Cough Describe:_____
   ☐Other_____
4. ADLs: (I=Independent, A=Assist D=Dependent)
   ___Feeding ___Toileting ___Grooming ___Dressing ___Driving ___Housework ___Cooking
5. HYGIENE: ☐Shower ☐Tub ☐Sponge
6. LEVEL OF EXERCISE: ☐ Sedentary ☐ Light ☐ Moderate ☐ High Times/week_____
7. OCCUPATION:_____
8. Other observations:_____

CARE CONCERNS

☐ Impaired Mobility
☐ Fall Risk
☐ Self Care Needs
☐ Activity Intolerance
Ineffective:
☐Breathing Pattern
☐Airway Clearance
☐ Decreased cardiac output
☐ Altered tissue perfusion
☐Impaired gas exchang
☐ Impaired home maintenance mgmt

SLEEP/REST

1. SLEEP: ☐No Problems ☐Difficulty falling asleep ☐Not rested after sleep ☐Other_____
   What helps you sleep?_____
   Sleep Routine: Bedtime_____ # of hours_____ # of pillows_____ ☐ Naps
2. Other observations:_____

CARE CONCERNS

☐ Sleep Pattern Disturbance

COGNITIVE/PERCEPTION

CARE CONCERNS

1. COMMUNICATION/LEARNING: PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other_____

Reading problems: ☐ No ☐ Yes:_____ Recent memory changes: ☐ No ☐ Yes:_____

Hearing: ☐ No Problems ☐ Impaired:_____ ☐ Aids - W/patient? ☐ Yes ☐ No

Vision: ☐ No Problems ☐ Impaired: _____ ☐ Glasses ☐ Contacts - W/patient? ☐ Yes ☐ No

Smell: ☐ No problems ☐ Impaired:_____ Taste: ☐ No problems ☐ Impaired:_____

Easiest way to learn: ☐ Read ☐ Demonstrate ☐ Video/TV ☐ Pictures ☐ Groups ☐ Individual instruction

Readiness to learn/motivation: ☐ Asks questions ☐ Eager to learn ☐ Anxious ☐ Denies need for education ☐ Uncooperative ☐ Unable to assess_____

2. PAIN/DISCOMFORT: ☐ None ☐ Yes: describe_____

Current Pain Level (1-10) _____ Acceptable level of pain: _____ How is pain controlled _____

Numbness/Tingling: ☐ None ☐ Yes

_____

3. Other observations:_____ _____

- ☐ Impaired Verbal Communication
- Sensory/Perceptual Alteration
  - ☐ Auditory
  - ☐ Gustatory
  - ☐ Olfactory
  - ☐ Visual
  - ☐ Kinesthetic
  - ☐ Tactile
- ☐ Pain
- ☐ Knowledge deficit (specify)

SELF-PERCEPTION/SELF-CONCEPT

CARE CONCERNS

1. EXPECTATIONS OR CONCERNS REGARDING YOUR HOSPITALIZATION? _____

_____

2. IS PATIENT'S BEHAVIOR APPROPRIATE TO SITUATION: ☐ Yes ☐ No Describe_____

3. Other observations_____ _____

- ☐ Anxiety
- ☐ Fear
- ☐ Powerlessness
- ☐ Hopelessness
- ☐ Body Image Disturbance

ROLE/RELATIONSHIPS

CARE CONCERNS

1. WHO DO YOU RELY ON FOR SUPPORT?_____

2. HOW WILL YOUR ILLNESS AFFECT YOUR FAMILY/SIGNIFICANT OTHER?_____

_____

3. Other observations:_____ _____

- ☐ Family Needs
- ☐ Parenting Needs

SEXUALITY/REPRODUCTION

CARE CONCERNS

1. SEXUALITY/REPRODUCTIVE: ☐ No Problems ☐ Changes/concerns:_____

2. FEMALES: Pregnant ☐ No ☐ Yes - Due date:_____ ☐ Receiving prenatal care from:_____

3. Last menses? _____ ☐ Post menopausal

4. Other observations: _____ _____

- ☐ Altered sexuality patterns
- ☐ Pregnancy
- ☐ Prenatal care needs

COPING/STRESS

CARE CONCERNS

1. HAS THIS ILLNESS CAUSED STRESS? ☐ No ☐ Yes_____

Do you feel you are dealing adequately with the stress? ☐ Yes ☐ No_____

2. HAVE YOU EVER SUFFERED FROM: ☐ Depression ☐ Emotional illness: _____ (Stop here if no hx)

Have you ever attempted suicide? ☐ No ☐ Yes, date:_____ If yes, Currently thinking about hurting yourself? ☐ No ☐ Yes

3. Other observations:

- ☐ Ineffective Coping
- ☐ Impaired adjustment
- ☐ Suicide Risk
- ☐ Post trauma response

VALUES/BELIEFS

CARE CONCERNS

1. CULTURAL OR RELIGIOUS PRACTICES IMPORTANT TO YOU DURING YOUR HOSPITALIZATION?

☐ None ☐ Yes:_____

Catholic Communion? ☐ Yes ☐ No

2. ADVANCED DIRECTIVES (e.g.Living will, Durable Power of Attorney)

☐ Yes ☐ No ☐ No, but would like more information

Special transfusion requests? ☐ No special requests ☐ Yes: (specify request)_____

3. Other observations:

- ☐ Spiritual Needs
- ☐ Cultural Needs
- ☐ Advanced Directive Needs
- ☐ Special transfusion needs

RN:_____ **RN:** _____

Name Date / Time Name Date / Time

Date_____ **Time**_____ # Physical Assessment

NUTRITION/METABOLIC PATTERN

Height:_____ Actual weight:_____kg Reported weight_____
Temp: _____ Last blood sugar (time/results)_____
General appearance, grooming, hygiene_____
_____
_____
Oral mucosa: ☐Moist ☐Dry ☐Lesions ☐other_____
Dentures ☐Upper ☐Full ☐Partial ☐Lower ☐Full ☐Partial
w/patient ☐Yes ☐No
Skin condition: ☐warm ☐dry ☐pale ☐dusky ☐cool ☐moist
☐lesions ☐color changes

(insert body diagram)

Other observations:_____
_____
_____

ELIMINATION

Intrvaneous, drainage, suction:
☐IV ☐Central line ☐PICC to_____
Catheter: ☐Foley Size_____ Urine color_____ amt____
Dialysis ☐catheter_____ ☐fistula_____
Last dialysis_____
Other observations_____
_____
_____
Abdomen: ☐Soft ☐Firm ☐Tender ☐Hard ☐Distended
Bowel sounds: ☐Present in all 4 quadrants ☐None
Other observations_____
_____
_____

(insert Braden Scale)

ACTIVITY/EXERCISE PATTERN

B/P: _____
Pulse:_____ Rate:_____ Rhythm:_____ Strength:_____
R: _____ Depth:_____ Rhythm:_____
Breath sounds: ☐Clear all 4 quadrants
☐Crackles_____ ☐Wheezes_____
☐Diminished_____ ☐Absent_____
Other observations_____
_____
_____
Balance: ☐Steady ☐Unsteady ☐Unable to stand
Gait: ☐Normal ☐Limps ☐Shuffles
ROM: ☐Full active ☐Passive ☐Restricted_____
☐Immobile_____
Grip strength:☐Equal, strong ☐Weak_____
☐Paralysis_____
Foot/leg strength: ☐Equal, strong ☐Weak_____
☐Paralysis_____
☐Joint swelling_____
☐Contractures_____ ☐Absent body part_____
Other observations_____
_____
_____

COGNITIVE/PERCEPTUAL PATTERN

Verbal response: ☐oriented ☐confused ☐ Inappropriate sounds
☐incomprehensible sounds ☐intubated/trach ☐none
Motor response: ☐follows instruction/spontaneous movement
☐withdraws from touch ☐withdraws from pain ☐flexes with pain
☐extends with pain ☐none
Communication: ☐Grasps ideas and questions (abstract, concrete)
☐aphasia ___receptive ___expressive ☐dysphagia ☐slurred speech
Memory: ☐observed short term memory lapses
☐other_____

EYES
Reads newsprint? ☐yes ☐no

EARS
Hears whispers ☐ yes ☐no

Other observations_____
_____

COPING/ROLE RELATIONSHIP/SELF-CONCEPT

Emotional status: ☐cooperative ☐uncooperative ☐anxious
☐combative ☐depressed ☐withdrawn ☐agitated
Interaction with family_____
Other observations_____
_____
_____

(Insert Hendrich's Fall Risk Scale)

RN:_____
Name Date Time