John T. Mather Memorial Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

RN3805

PATIENT INSTRUCTIONS: Complete this section on each page or have someone complete it for you. Answer by "✓" when appropriate.

PERSONAL INFORMATION

Scheduled procedure:

Person providing information: Relationship: Legal Guardian if child:

Family Doctor: Phone # Medical Evaluation ❑ Yes Date:_____ N/A

Age: Height: Weight: Weight 1 year ago:

Have you signed up as an organ donor? ❑ Yes ❑ No Do you have a DNR?❑ Yes ❑ No

Health Care Proxy? ❑ Yes ❑ No Bringing Copy ❑

If yes, name of proxy _____

Phone number: _____

If no ❑ Pt executes a health care proxy (copy placed in chart)

❑ Patient refuses at this time. Education provided

Medications **TAKEN REGULARLY** (Prescription, over the counter, diet aides, home remedies, herbs or vitamins):

Name of Medication	Dose & Frequency	Reason for Taking

Have you had any changes in medications in the past 30 days? ❑ Yes ❑ No

If yes explain:

PREVIOUS SURGERIES DATES ❑ None

Previous Hospitalization (Pediatrics Only)

❑ Smoking History ❑ Now ❑ Past ❑ Never

❑ Counseled if presently smoking or quit less than 1 yr. ago

❑ Alcohol Use ❑ Now ❑ Past ❑ Never

How Much?_____

❑ Drugs (recreational) ❑ Now ❑ Past ❑ Never

Type_____

PEDIATRICS ONLY:

Birth history: ❑ c-section ❑ vaginal delivery

Full term ❑ Yes ❑ No

If no explain:_____

Are Immunizations up to date? ❑ Yes ❑ No

If no: Information given ❑ Yes ❑ Refused

Is child up to date with well visits? ❑ Yes ❑ No

Does the Pediatrician have any concerns regarding Child's growth and development? ❑ Yes ❑ No

If yes explain:_____

Has the child's growth of development been affected by their present condition? ❑ Yes ❑ No

If Yes explain _____

DISCHARGE PLANNING

Please state anything else you think we should know

_____

Do you have specific requests for support or counseling? ❑ Yes ❑ No

❑ Spiritual/Cultural needs ❑ Family Issues/Work issues

❑ Coping strategies ❑ Other_____

Where are you planning to go upon discharge:

❑ Home ❑ Other _____

Who will be responsible for your transportation and care at home?

Name:_____

Phone No. _____

Patient Name_____ Patient #_____

PLEASE (✓) APPROPRIATE BOXES — DO NOT WRITE IN BLANK AREAS

PATIENT HISTORY

NEUROLOGICAL PSYCHOLOGICAL/HEAD/NECK TRAUMA ❑ NO PROBLEMS

❑ Headaches
❑ Weakness/paralysis ❑ Dizziness/difficulty with balance
❑ Stroke ❑ Speech slurred/difficulty speaking ❑ Seizures
❑ Memory problems/difficulty learning
❑ Unconsciousness/fainting ❑ Depression ❑ Bipolar Disorder
Comments_____

EYES/EARS/NOSE/THROAT ❑ NO PROBLEMS

❑ Visual impairment ❑ Hearing impairment ❑ Glaucoma
❑ Ringing in ears ❑ Cataracts ❑ Deviated septum/sinus problems
❑ Dry eyes/corneal abrasion ❑ Glasses/contacts ❑ Hearing aid(s)
Comments_____

RESPIRATORY / LUNGS ❑ NO PROBLEMS

❑ Pneumonia/Recent cold or flu
❑ Loud Snoring/ Sleep Apnea ❑ Chronic cough/Cough w/ mucus
❑ Shortness of breath ❑ Wheezing /Asthma ❑ Croup
❑ Emphysema/COPD ❑ Periods of no breathing
❑ Monitoring equipment used at home_____
Comments_____

VASCULAR/HEART ❑ NO PROBLEMS

❑ Chest pain, palpatations, shortness of breath, fainting episodes
❑ Irregular Heart Beat ❑ Murmur, Valve Disorder
❑ high/low Blood Pressure ❑ heart attack/blockage
❑ Abnormal EKG ❑ Pacemaker ❑ Defibrillator
❑ Circulatory problems, Swelling of feet/ankles, varicose veins
Blood Clots ❑ Yes ❑ No If yes, where_____
Comments_____

BLOOD/INFECTIOUS DISEASE ❑ NO PROBLEMS

❑ Anemia ❑ Transfusion Reaction ❑ Easy bruising/Bleeding Disorder
❑ Lyme Disease ❑ Frequent nosebleeds ❑ Other_____
❑ Tick Bite ❑ Hepatitis ❑ TB or Positive Test
Comments_____
Transfusion ❑ Yes ❑ No If yes: reaction ❑ Yes ❑ No

GASTROINTESTINAL/BOWEL, DIGESTIVE ❑ NO PROBLEMS

❑ Special diet/difficulty swallowing, eating
❑ Jaundice/Hepatitis ❑ Gallbladder Disease
❑ Recent nausea/vomiting ❑ Heartburn/excessive burping
❑ Chronic diarrhea/constipation ❑ Stomach ulcer/hiatal hernia
❑ Rectal bleeding ❑ Diverticulitis ❑ Liver Disease
Last Rectal Exam_____ Last Colonoscopy_____
Comments_____

GENITOURINARY ❑ NO PROBLEMS

❑ Kidney disease/Dialysis ❑ Kidney Stones
❑ Difficulty / Frequent urination
❑ Loss of bladder control ❑ Blood in urine
❑ Pain/burning on urination
❑ Sexually transmitted diseases ❑ Bed Wetting
Females: Last Breast Exam_____
Last Mammography_____ Last Pap Smear_____
Last menstrual period_____ Pregnant? ❑ Yes ❑ No ❑ Maybe
Males: Last PSA_____ ❑ Prostate Disease
Comments_____

MUSCULOSKELETAL/EXTREMETIES ❑ NO PROBLEMS

❑ Arthritis ❑ TMJ pain or jaw disorder ❑ Sciatica ❑ Gout
❑ Artificial joint(s) ❑ Muscle disease/weakness ❑ Osteoporosis
❑ Mobility restriction ❑ Neck/back problem ❑ Fractures
❑ Physical Therapy ❑ Scoliosis
Comments_____

SKIN ❑ NO PROBLEMS

❑ Non-healing sores/ulceration ❑ Skin disorder ❑ Skin Cancer
Comments_____

ENDOCRINE ❑ NO PROBLEMS

❑ Diabetes ❑ Low blood sugar ❑ Thyroid/hormone disorder
Comments_____

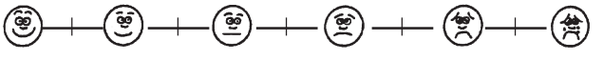
CANCER - Type: Date _____
If within 1 year: Oncologist: _____
Stage:_____ Treatment:_____

PAIN ❑ NO PROBLEMS

Do you have any previous or ongoing problems with pain? ❑ Yes ❑ No
If yes, What has been used to control pain?_____
_____
Pain Relief Goal_____(0-10)
Comments_____
_____

Circle Pain Intensity Scale Number

0 1 2 3 4 5 6 7 8 9 10



No pain Mild Moderate Severe Very Severe Worst Possible

Needs/problems have been identified and planning done based on information from this data base and a biophysical assessment. **Briefly describe patients emotional status** _____ .
Anticipated Discharge needs: _____
Signature of RN/NP initiating care: _____Date _____