AKRON GENERAL HEALTH SYSTEM®
400 Wabash Avenue, Akron, Ohio 44307, 330-344-6000
4125 Medina Road, Akron, Ohio 44333, 330-665-8121

Date:

Explain any items marked *_____

_____

_____

_____ **Reviewer:** _____ **Date:** _____

OUTPATIENT DEPARTMENT USE ONLY **-** Refer to other applicable forms ❑ *Screening Assessment for Interdisciplinary Referrals

Skin Integrity Impairment Assessment:
If any of the following factors are noted the patient is at moderate to high risk of pressure ulcers; refer to intervention*.

- ❑ **Impaired Nutrition.**
- ❑ **Activity:** Full lift, Chair bound, Bedrest > 8 hrs, OR time > 3 hrs.
- ❑ **Mobility:** Restrained, immobile, assist to full turn.
- ❑ **Continence:** Incontinence.
- ❑ **Skin Condition:** Fragile, open lesions.
- ❑ **Impaired Circulation, Peripheral Vascular Disease.**

Fall Risk Assessment
(if added scores 5 or >, refer to Intervention*):

Altered Cerebral Function	= 5
Previous Falls	= 4
Impaired Mobility	= 3
Sensory Perceptual Impairment	= 2
Elimination Problems	= 1
Age > 70	= 1
Medication Effects (Sedative, Narcotic, Cardiovascular, Psychotropics)	= 1

TOTAL SCORE: _____

T _____ P _____
R _____ BP _____
Pain (0-10) _____
Weight _____
Height _____
R = Respirations

Have you had a sudden change in safely walking, moving or in ability to care for yourself? ❑ Yes* ❑ No
Have you recently experienced difficulty in speaking or swallowing? ..... ❑ Yes* ❑ No
Weight loss greater than 10 pounds in the last 3 months? ..... ❑ Yes* ❑ No

Initials_____
Date_____

PHYSICIAN USE ONLY

History Present Illness/Chief Complaint:_____

_____

_____

Past Medical History: ❑ **See Other Side**

Surgical: _____
Medical: _____
Cardiac: _____
Respiratory: _____
Metabolic (Diabetes): _____
Other (HTN, Bleeding Disorders, etc.): _____

Current Medications: ❑ **See Other Side** _____

_____

_____

Allergies: ❑ **See Other Side** _____

Examination: T_____ P_____ R_____ BP_____ Pain Level (0-10)_____ Wt._____ ht._____ ❑ **See Above**

	WNL	Comments:		WNL	Comments:
Mental Status	❑	_____	Abdomen	❑	_____
EENT	❑	_____	Ortho.	❑	_____
Heart	❑	_____	GYN/Urology	❑	_____
Lungs	❑	_____	Other	❑	_____

Diagnosis: _____

_____

Procedure: _____

_____

Anesthesia Requested: ❑ Local ❑ M.A.C. ❑ CS ❑ General ❑ Regional ❑ Block _____

Physician Signature: _____ Date: _____

This short form history and physical may be used for all outpatient services. Upon observation or inpatient admission, a detailed interim note explaining the reason for the change in status is needed.

(E.F. 100-007) Form P1846A ... [91/051104] ... Reorder# M30197

DT100

PATIENT HEALTH HISTORY / PHYSICAL

TAB (SALMON/BEIGE): HISTORY & PHYSICAL

AKRON GENERAL HEALTH SYSTEM®
400 Wabash Avenue, Akron, Ohio 44307, 330-344-6000
4125 Medina Road, Akron, Ohio 44333, 330-665-8121

DATE:

Completed For:
*(patients name)*_____

Reason for Visit *(patient's own words)*: _____

In case of emergency contact _____ Relationship _____ Phone _____

Living arrangements: ❑ Lives Alone ❑ Live with family at home ❑ Live in extended care facility ❑ Other: _____

Do you plan to return to current living arrangement? ❑ Yes ❑ No* *Explain:* _____

Do you need help in caring for yourself? ❑ Yes* ❑ No *Explain:* _____

Do you need / use medical equipment at home? ❑ Yes* ❑ No *Explain:* _____

Health Habits: ..... Alcohol? ❑ Yes ❑ No Number of drinks per day _____ Quit _____

Tobacco? ❑ Yes ❑ No Number per day _____ Number of Years _____ Quit _____

Recreational Drug Use? ❑ Yes ❑ No Substance _____ Frequency _____ Quit _____

Have you had any recent exposure to communicable disease (TB, chicken pox, measles, Venereal Disease, etc.?) ❑ Yes* ❑ No *Explain:* _____

Do you have cultural / religious requests? ❑ Yes* ❑ No *Explain:* _____

Immunizations current? ❑ Yes ❑ No* ❑ Unknown *Explain:* _____

Are you currently in a situation or relationship in which you feel unsafe? ❑ Yes* ❑ No *Explain:* _____

Have you or family members had problems with anesthesia? ❑ Yes* ❑ No, *Explain:* _____

Year	Past Surgery, Anesthesia, Hospitalization, Medical History, Dental, Childbirth

ALLERGIES
(❑ see allergy assessment form)

Current Medications
(include over-the-counter, herbs, vitamins & home remedies)

❑ *Unable to give medication history**

Medication	Dose	How Often

Review of Systems
(Check all that apply)
Check **S** for Self.
Check **F** for Family

❑ Glasses ❑ Contacts
❑ Blind
❑ Right ❑ Left
❑ Hearing Aids
❑ Right ❑ Left
❑ Dentures
❑ upper ❑ lower
❑ Prosthetic Device*

S F *Head / Neck*
❑ ❑ Glaucoma

S F *Heart*
❑ ❑ Chest pain / Angina
❑ ❑ High blood pressure
❑ ❑ Heart attack
❑ ❑ Pacemaker / ICD
❑ ❑ Blood clots or Phlebitis
❑ ❑ Mitral Valve Prolapse

S F *Endocrine*
❑ ❑ Diabetes
❑ ❑ Thyroid disease
❑ ❑ Hepatitis

S F *Psychosocial*
❑ ❑ Mental health disorder
❑ ❑ Anxiety
❑ ❑ Depression
❑ ❑ Trouble Coping
❑ ❑ Limited Support System

S F *Skin:*
❑ ❑ Rash

S F *Lungs*
❑ ❑ Asthma
❑ ❑ Chronic Bronchitis
❑ ❑ Emphysema
❑ ❑ Sleep Apnea
❑ ❑ TB
❑ ❑ Cough

S F *Gastrointestinal*
❑ ❑ Ulcer
❑ ❑ Bowel Problems
❑ Ostomy type*

S F *Bones / Muscles*
❑ ❑ Muscle weakness
❑ ❑ Arthritis

S F *Blood*
❑ ❑ Bleeding tendency
❑ ❑ Other

S F *Cancer*
❑ ❑ Type _____
Treatment _____

S F *Nervous System*
❑ ❑ Seizures
❑ ❑ Stroke
❑ ❑ Fainting / dizziness

S F *Kidneys*
❑ ❑ Kidney disease
❑ ❑ Urinary infection
❑ ❑ Urinary problems

Reproductive
Are you currently pregnant? ❑ yes ❑ no
Last menstrual period: _____
❑ Prostate Problems

Pain History
❑ no problem
Rate Pain (0-10) _____
Location _____
Duration _____
Characteristic _____
Frequency _____
Aggravating factors _____
_____
_____
Alleviating Factors _____
_____
_____

Completed By: *(your name* Date:
X_____ _____

Reviewer: Date:
X_____ _____

(E.F. 100-007) Form P1846A ... [91/051104] ... Reorder# M30197

PATIENT HEALTH HISTORY / PHYSICAL
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