Symetria RECOVERY

Nursing Assessment

Patient Name: ______________________ Today's Date: __________

Date of Birth: ____________ Age: ______________

Height: ____________ Weight: ____________ SSN: _______________________

Emergency Contact: (Name and Number) ____

Medical History

Eyes: ___ Change in vision / eye pain, redness, Glaucoma ___ **No problems**
Ears/Nose/Throat: ___ Nosebleeds, trouble swallowing ___ Frequent sore throat, hoarseness ___ Hearing loss / ringing in ears ___ **No problems**
Skin: ___ New or change in mole ___ Rash / itching ___ **No problems**
Cardiovascular: ___ Chest pain / discomfort ___ Palpitations (fast or irregular heartbeat) ___ **No problems**
Respiratory: ___ Cough / wheeze ___ Loud snoring / altered breathing during sleep ___ Short of breath with exertion ___ **No problems**
Gastrointestinal: ___ Heartburn / reflux / indigestion ___ Blood or change in bowel movement ___ Constipation ___ **No problems**
Genitourinary: ___ Leaking urine ___ Blood in urine ___ Nighttime urination or increased frequency ___ Discharge: penis or vagina ___ Concern with sexual function ___ **No problems** **STI Screening:** ___ Hx of Unprotected Sex ___ Sex for drugs ___ Blood Transfusions ___ Shared Needles **Are you aware of your HIV Status?** Y or N **Any Known STI?** Y or N

Neurological:	___ Headache	___ Memory loss	___ Fainting	___ Dizziness	
	___ Numbness / tingling	___ Unsteady gait	___ Frequent falls	**___ No problems**	
Musculoskeletal:	___ Neck pain	___ Back pain	___ Muscle / joint pain	**___No problems**	
Endocrine:	___ Diabetes (Type: ___)	___ Thyroid problems	**___ No problems**		
Hematologic/Lymphatic:	___ Swollen glands	___ Easy bruising	**___ No problems**		
Allergic/immune:	___ Hay fever / allergies	___ Frequent infections	**___ No problems**		

IMMUNIZATIONS: Add year, if known

Dates Unknown □

Tetanus (Td): ______ With Pertussis (Tdap): ______ Varicella (Chicken Pox) shot *or* illness: ______

Pneumovax (pneumonia): ______ Influenza (flu shot): ______ Hepatitis A: ______

Hepatitis B: ______ MMR: ______ Meningitis: ______ Zostavax (shingles): ______

HPV: ______

Medical / Surgical History:

___ Cancer ___ Kidney ___ Disease ___ Blood Disorders ___ Gout Bladder problems
___ Neurological Disorders ___ High Blood Pressure ___Urinary Tract Infections ___ Stomach Ulcers
___ Stroke ___ Liver Disease ___ MI ___ Hepatitis ___ Tuberculosis ___ Thyroid Problems
___ Heart Disease ___ Emphysema/ COPD ___ Pacemaker ___ Congestive Heart Failure
___ Asthma ___ Diabetes ___ Depression ___ Anxiety ___ HIV/AIDS ___ High Cholesterol
___ Osteoporosis ___ Psychiatric disorder ___ Arthritis Rheumatoid ___ Arthritis Headaches
Other/ Comments____

Surgical History:

____
____
____

Do you use any alternative therapies? _________________________

How would you rate your diet - Good ___ Fair ___ Poor ___

Do you restrict what you eat? ___ Do you worry about your weight? ___

Do you think you eat too much? ___ Do you eat a balanced diet? ___

WOMEN'S HEALTH HISTORY: **Are you currently pregnant? _____**

Total number of pregnancies: _____ Number of births: _____

Date of last menstrual period: ____________ Age at beginning of periods (menstruation): _____

Age at end of periods (menopause): _____

Do you exercise regularly? Yes___ No___ Type _______________ How often ______________

Safety

Do you use seatbelts consistently? ____ Is violence at home a concern for you? ____________ Do you have a working smoke detector? ____________

End-of-Life Planning

End-of-Life Planning consists of a legal document (e.g. Living Will, Advanced Directive) that explains your wishes should you become incapacitated and unable to express your wishes regarding life-saving/sustaining medical interventions.

Have you established a Living Will or Advanced Directive? _____Yes _____ No

If you answered "No", would you like more information regarding obtaining end-of-life planning? ______ Yes ______No

Current Medications

Medication Name	Strength	Frequency	Route	Condition for which medication is prescribed

Do Your medications work for you? Yes ___ No ___

Allergies

Allergies to medication/foods/environmental	Reaction

Any Significant family medical History? ___ Y or ___ N

(describe)____

Vitals (completed by staff): B/P ___________ Pulse ___________ Temp ___________ R/R ___________