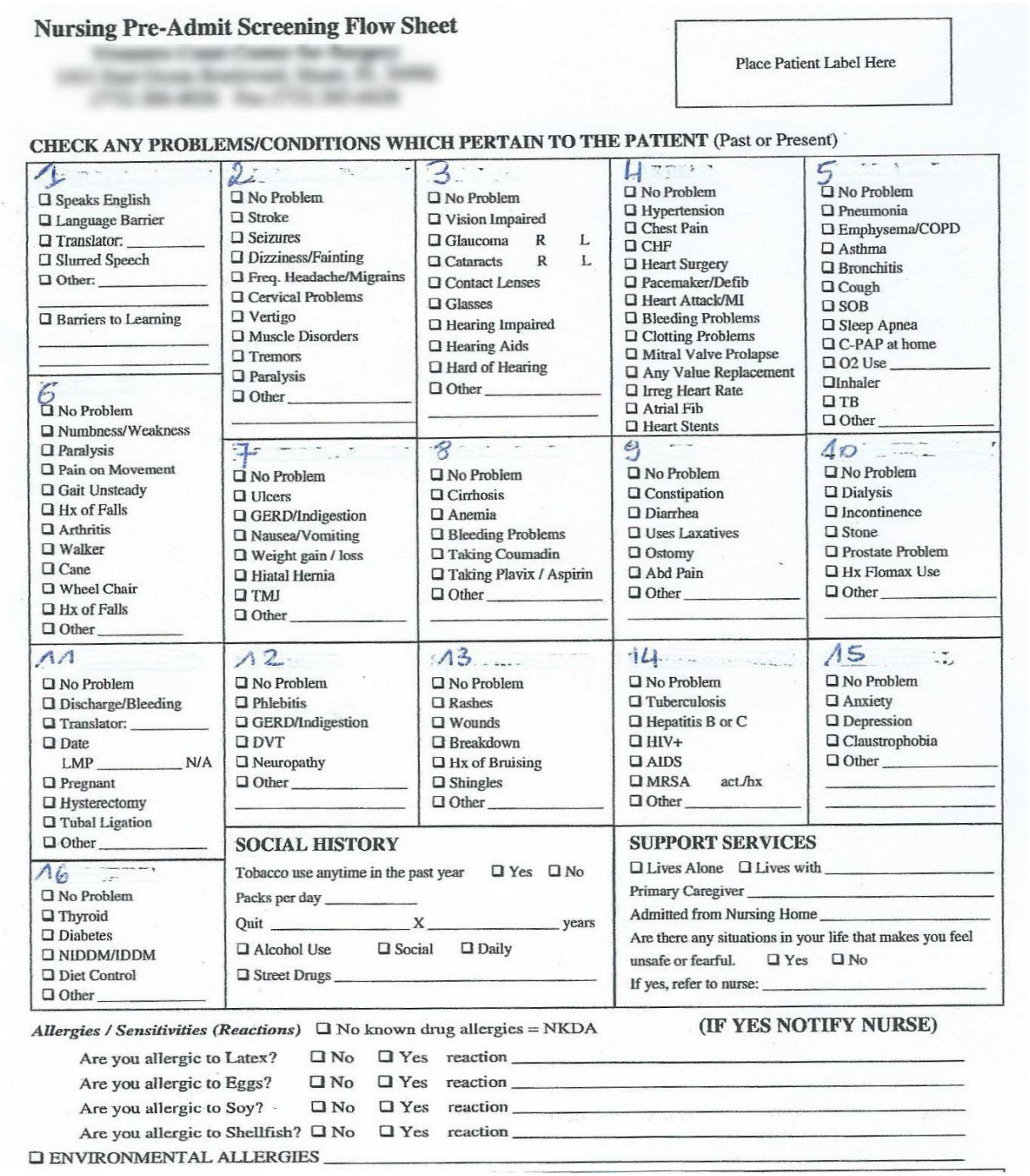

Nursing Pre-Admit Screening Flow Sheet

Place Patient Label Here

CHECK ANY PROBLEMS/CONDITIONS WHICH PERTAIN TO THE PATIENT (Past or Present)

1
- ☐ Speaks English
- ☐ Language Barrier
- ☐ Translator: _____
- ☐ Slurred Speech
- ☐ Other: _____
- ☐ Barriers to Learning

2
- ☐ No Problem
- ☐ Stroke
- ☐ Seizures
- ☐ Dizziness/Fainting
- ☐ Freq. Headache/Migrains
- ☐ Cervical Problems
- ☐ Vertigo
- ☐ Muscle Disorders
- ☐ Tremors
- ☐ Paralysis
- ☐ Other _____

3
- ☐ No Problem
- ☐ Vision Impaired
- ☐ Glaucoma R L
- ☐ Cataracts R L
- ☐ Contact Lenses
- ☐ Glasses
- ☐ Hearing Impaired
- ☐ Hearing Aids
- ☐ Hard of Hearing
- ☐ Other _____

4
- ☐ No Problem
- ☐ Hypertension
- ☐ Chest Pain
- ☐ CHF
- ☐ Heart Surgery
- ☐ Pacemaker/Defib
- ☐ Heart Attack/MI
- ☐ Bleeding Problems
- ☐ Clotting Problems
- ☐ Mitral Valve Prolapse
- ☐ Any Value Replacement
- ☐ Irreg Heart Rate
- ☐ Atrial Fib
- ☐ Heart Stents

5
- ☐ No Problem
- ☐ Pneumonia
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cough
- ☐ SOB
- ☐ Sleep Apnea
- ☐ C-PAP at home
- ☐ O2 Use _____
- ☐ Inhaler
- ☐ TB
- ☐ Other _____

6
- ☐ No Problem
- ☐ Numbness/Weakness
- ☐ Paralysis
- ☐ Pain on Movement
- ☐ Gait Unsteady
- ☐ Hx of Falls
- ☐ Arthritis
- ☐ Walker
- ☐ Cane
- ☐ Wheel Chair
- ☐ Hx of Falls
- ☐ Other _____

7
- ☐ No Problem
- ☐ Ulcers
- ☐ GERD/Indigestion
- ☐ Nausea/Vomiting
- ☐ Weight gain / loss
- ☐ Hiatal Hernia
- ☐ TMJ
- ☐ Other _____

8
- ☐ No Problem
- ☐ Cirrhosis
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Taking Coumadin
- ☐ Taking Plavix / Aspirin
- ☐ Other _____

9
- ☐ No Problem
- ☐ Constipation
- ☐ Diarrhea
- ☐ Uses Laxatives
- ☐ Ostomy
- ☐ Abd Pain
- ☐ Other _____

10
- ☐ No Problem
- ☐ Dialysis
- ☐ Incontinence
- ☐ Stone
- ☐ Prostate Problem
- ☐ Hx Flomax Use
- ☐ Other _____

11
- ☐ No Problem
- ☐ Discharge/Bleeding
- ☐ Translator: _____
- ☐ Date
  LMP _____ N/A
- ☐ Pregnant
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Other _____

12
- ☐ No Problem
- ☐ Phlebitis
- ☐ GERD/Indigestion
- ☐ DVT
- ☐ Neuropathy
- ☐ Other _____

13
- ☐ No Problem
- ☐ Rashes
- ☐ Wounds
- ☐ Breakdown
- ☐ Hx of Bruising
- ☐ Shingles
- ☐ Other _____

14
- ☐ No Problem
- ☐ Tuberculosis
- ☐ Hepatitis B or C
- ☐ HIV+
- ☐ AIDS
- ☐ MRSA act./hx
- ☐ Other _____

15
- ☐ No Problem
- ☐ Anxiety
- ☐ Depression
- ☐ Claustrophobia
- ☐ Other _____

16
- ☐ No Problem
- ☐ Thyroid
- ☐ Diabetes
- ☐ NIDDM/IDDM
- ☐ Diet Control
- ☐ Other _____

SOCIAL HISTORY

Tobacco use anytime in the past year ☐ Yes ☐ No

Packs per day _____

Quit _____ X _____ years

☐ Alcohol Use ☐ Social ☐ Daily

☐ Street Drugs _____

SUPPORT SERVICES

☐ Lives Alone ☐ Lives with _____

Primary Caregiver _____

Admitted from Nursing Home _____

Are there any situations in your life that makes you feel unsafe or fearful. ☐ Yes ☐ No

If yes, refer to nurse: _____

Allergies / Sensitivities (Reactions) ☐ No known drug allergies = NKDA **(IF YES NOTIFY NURSE)**

Are you allergic to Latex? ☐ No ☐ Yes reaction _____

Are you allergic to Eggs? ☐ No ☐ Yes reaction _____

Are you allergic to Soy? ☐ No ☐ Yes reaction _____

Are you allergic to Shellfish? ☐ No ☐ Yes reaction _____

☐ ENVIRONMENTAL ALLERGIES _____

Find the corresponding title for each of the 16 boxes above

Behavioral	n°
Bladder / kidney	n°
Blood / liver	n°
Bowel	n°
Cardiac	n°
Communication	n°

Endocrine	n°
Eye/Ears	n°
Infectious diseases	n°
Mobility	n°
Mouth/stomach	n°
Neuro/head/neck	n°

Reproductive	n°
Respiratory	n°
Skin problems	n°
Vascular	n°