Addressograph

Home: ( ) - Work: ( ) -
PHN:
Gender: DOB: Age:
Physician Name:

Data Base 1

1. Reason for appointment / admission

In the following sections, please check (√) boxes and / or circle your answers:

2. Health History

- ☐ jaw / neck problems
- ☐ seizures
- ☐ stroke
- ☐ blackouts
- ☐ rheumatic fever
  - ☐ bleeding problems
  - ☐ blood clots
- ☐ anemia
- ☐ heart problems
  - ☐ chest pain / angina
  - ☐ heart attack
- ☐ high blood pressure

Without stopping, can you climb

- ☐ 10 or more stairs
- ☐ less than ten stairs

- ☐ lung problems
  - ☐ bronchitis
  - ☐ TB
  - ☐ shortness of breath
  - ☐ sleep apnea
  - ☐ asthma requiring hospitalization
- ☐ stomach / bowel problems
  - ☐ acid taste when lying down
- ☐ kidney / bladder problems
- ☐ joint / bone problems

- ☐ steroids (eg: Prednisone, Cortisone
- ☐ diabetes
- ☐ thyroid problems
- ☐ hepatitis / jaundice
- ☐ HIV / AIDS
- ☐ radiation/chemotherapy treatments
- ☐ depression
- ☐ mental illness
- ☐ weight gain / loss
- ☐ conditions that run in the family (eg. muscular dystrophy / thalassaemia)
- ☐ other _____

If you have checked any of the above boxes, please **describe your symptoms** and how long you have had them

3. Allergies: Please list drugs, food and others and your reaction (eg: rash, fever, hives, swelling):

ALLERGIC TO	REACTION	ALLERGIC TO	REACTION

4. Previous Hospitalizations, surgeries and tests:

REASON	WHEN	WHERE

Have you ever received blood products? ◯ yes ◯ no Reaction? ◯ yes ◯ no

Have you, or a family member, ever had a reaction to anaesthetics? ◯ yes ◯ no

Explain: _____

5. Do you smoke? ◯ yes ◯ no

Quit when? _____ # of years _____ Packs / day _____

Do you drink alcohol? ◯ yes ◯ no How much? _____ How often? _____

Do you use street drugs? ◯ yes ◯ no Type _____

6. First day of last menstrual period _____ Are you pregnant? ◯ yes ◯ no

Addressograph

Data Base 2

Home: ( ) - Work: ( ) -
PHN:
Gender: DOB: Age:
Physician Name:

7. Medications

Please list **ALL** your medications. Include prescriptions (eg: inhalers, sleeping pills, birth control pills, patches) and over-the-counter medications (eg: aspirin, cold/allergy preparations, laxatives, vitamins, herbal/alternative medications):

DRUG NAME	DOSE AMOUNT	TIMES TAKEN	DRUG NAME	DOSE AMOUNT	TIMES TAKEN

8. Daily Living: Please check (√) boxes and / or circle your answers:

Language: ☐ English ☐ other _____

Religion: _____ Special customs: _____

Diet: ☐ regular ☐ special
Type of diet _____

Dental: ☐ no problems
☐ denture - upper / lower / partial
☐ capped teeth Comments _____

Sight: ☐ no problems ☐ glasses / contacts
☐ artificial eye ☐ blind
Comments _____

Hearing: ☐ no problems ☐ impaired
☐ hearing aid ☐ deafness
Comments _____

Walking: ☐ no problems ☐ assisted
☐ prosthesis Comments _____

Do you live alone? ◯ yes ◯ no

With whom do you live? _____

Plans to go home:
a. Who will take you home? _____
b. Do you have help at home? ◯ yes ◯ no
Comments _____

Do you receive any of these services:
☐ Social Services ☐ Home Care ☐ PT
☐ Meals on Wheels ☐ DATS ☐ OT
☐ Home Oxygen Therapy ☐ Hired Services
☐ Day Program ☐ Community Mental Health
☐ other _____

9. Other comments:

Date: _____ Information provided by: _____
Relationship to patient _____

Thank you for your assistance in completing the Data Base. This information may be shared with other health institutions or professionals involved in your care.

For Health Care Professional's Use: T _____ P _____ R _____ BP _____ Ht.(cm) _____ Wt.(kg) _____ BMI _____

Comments

Date _____ Signature _____
(Signature of Health Care Professional)

Admission: Date: _____ Has any of this information changed? ◯ yes ◯ no LMP _____

Explain:

Date _____ Signature _____
(Signature of Health Care Professional)