LAMONT HEALTH CARE CENTRE

Nursing Admission

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
Steroids (eg. Prednisone, Cortisone)

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
Ulcers
Kidney/bladder problems
Diabetes

Joint/bone problems
Arthritis
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)
Cancer
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

Abnormal bleeding associated with previous surgery or trauma. Yes No
Do you have any blood disorder or bruise easily? Yes No
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

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. Women: First day of last menstrual period _____ Are you pregnant? yes no

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7. **Medications:**
Please list **ALL** YOUR MEDICATIONS. Include prescriptions (e.g. inhalers, Sleeping pills, birth control pills, patches) and over-the-counter Medications (e.g. 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: _____
Body Jewelry: _____
Walking: no problems assisted
prosthesis Comments: _____
Other 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 _____

Date: _____ **Information provided by:** _____
Relation 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) ___
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)