

Admission Medical History and Physical Assessment

Name of Individual:		Age:	County of Record:	
Individual's Hospital Number:		Penal Code:		
Date of Admission:		Legal Hold:		
A. MEDICAL HISTORY				
1. CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESSES AND THEIR TREATMENTS				
Describe: <input type="checkbox"/> Unable to assess				
A. Current / Recent Medications: <input type="checkbox"/> See Admission Psychiatric Evaluation, or record medications in chart below:				
Medication	Dosage	Frequency	Time/Date of last dose	Duration of Treatment
2. PAST MEDICAL HISTORY				
A. Public Health History:		<input type="checkbox"/> History of Hepatitis B and/or C <input type="checkbox"/> History of Immunizations		
<input type="checkbox"/> Positive TB skin test or History of TB: <input type="checkbox"/> Exposure to STD's MRSA, Unspecified viral illness <input type="checkbox"/> None Significant		<input type="checkbox"/> History of Hepatitis B and/or C <input type="checkbox"/> History of Immunizations		
B. Other Medical History: <input type="checkbox"/> Non Significant				
C. Surgical History other than above: <input type="checkbox"/> None Significant				
D. Injuries other than above: <input type="checkbox"/> None Significant				
E. Head Trauma: <input type="checkbox"/> None Significant				
F. Previous Adverse Drug Reactions: <input type="checkbox"/> None Significant				
G. Allergies: <input type="checkbox"/> No known allergies <input type="checkbox"/> See Admission Psychiatric Evaluation, or Describe:				
3. FAMILY HEALTH HISTORY				
Mother:				
Father:				
Siblings:				
Other Relatives/Marriages/Significant Other:				
None known or unable to assess <input type="checkbox"/>				
4. TRAVEL / OCCUPATIONAL HISTORY				
Previous Residence Type:				

Travel:				
Occupations including military service:				
<input type="checkbox"/> Unable to assess				
5. SUBSTANCE USE HISTORY				
Smoking:				
<input type="checkbox"/> None				
Alcohol:				
<input type="checkbox"/> None				
Illicit Drugs:				
<input type="checkbox"/> None				
Other:				
<input type="checkbox"/> None				
Unable to assess: <input type="checkbox"/>				
B. REVIEW OF SYSTEMS				
Presence or history of any of the following?				
Describe any "Yes" or "Unable to assess" (UA) answer.				
1. GENERAL				
A. Appetite/Weight Changes:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
B. Chills, Fevers, Night Sweats:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Sleep Problems:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Prone to Infections:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Excessive Fatigue:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Chronic Pain:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Fainting Spells:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Other (Specify):	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
2. EYES, EARS, NOSE and THROAT				
A.1 Eyes: Changes in Eyesight, Double Vision, Other Eye Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
A.2 Wears Corrective Lenses:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
B.1 Ears: Deafness, Ringing in Ears, Infection, Other	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
B.2 Wears Hearing Aid(s)	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Nose: Congestion, "Runny", "Bleeding", Loss of Smell, Other Nasal Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Dental Problems:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Wears Dentures:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:

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Throat, Larynx: Frequent Sore Throats, Change in Voice/Hoarseness, Other:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Difficulty Swallowing/ Choking:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
3. RESPIRATORY				
A. History of Asthma or Wheezing:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
B. Chronic Cough, Shortness of Breath, Other Coughing up colored mucus or blood/Pneumonia:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
4. CARDIOVASCULAR				
Heart: Chest Pains on Exertion, Breathing Difficulty Lying Down, Irregular Heart Rhythm, History of Murmur, Other:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
History of High or Low Blood Pressure:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Ankle(s) Swelling:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Arterial: Pains in Leg(s) After Walks, Other:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Venous: Varicose Veins, Other:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
5. GASTROINTESTINAL				
Liver: History of Jaundice or Hepatitis (type?), Other:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Gastroesophageal: Heartburn, Pains, Acid Reflux, History of Peptic Ulcer, Nausea/ Vomiting, Other:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Intestinal: Diarrhea, Constipation, Black Tarry Stools, Rectal Bleeding, Hemorrhoids, Other:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Food Intolerance	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:

6. GENITO-URINARY (SEE ALSO WOMEN'S HEALTH, ITEM #12 BELOW)				
Lower Urinary Tract: Frequency, Urgency, or Burning on Urination; Urinary Incontinence, Blood in Urine, Urinary Hesitance/Slow Stream, Other:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
History of Infection in Urinary Tract, Including STDs, Urethral Discharge:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Kidneys/Ureters: Stones, Flank Pain, Other:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
(Males Only) Erection Prostate Problems, Other male Genital Problems:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
(Females Only) Vaginal Discharge/ Odor Vaginal or Pelvic Pain, Other Gynecological Problems:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
7. MUSCULOSKELETAL, EXTREMITIES				
Back Pain/Injury (Acute, Chronic, Recurrences):	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Arthritis, Fractures, or Bone Diseases:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Pain in Extremities:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
Muscular Weakness, Other Muscle Problems:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
8. NEUROLOGICAL				
A. Frequent Headaches	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
B. Seizure/ Convulsion, Epilepsy	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
C. Shaking or Twitching of the Muscles (including EPS):	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
D. Stroke, Loss of Sensation or Movement in Any Part of the Body, Head Injuries:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
E. Loss of Balance, Falling:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
F. Memory Loss:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:
9. DERMATOLOGICAL				

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Rashes, Itching, Skin Disease History, Other skin problems:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:		
Nail or Hair Diseases:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:		
Lumps/Nodules:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:		
10. ENDOCRINOLOGICAL						
Diabetes History, High Blood Sugar Readings:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:		
Treatment for Thyroid Disease, Intolerance of Heat or Cold:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:		
Other Endocrine Disorders:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:		
11. HEMATOLOGICAL/IMMUNOLOGICAL						
Anemia:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:		
Bruise Easily:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:		
Immune System Disorders:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:		
Other:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	UA <input type="checkbox"/>	Describe:		
12. (FEMALES ONLY) WOMEN'S HEALTH						
Gravida: _____	Para: _____	Ab: _____	UA			
Last Menstrual Period – Date: Unable to assess: <input type="checkbox"/>						
Last Mammogram – Date: History of Abnormal Mammograms: Unable to assess: <input type="checkbox"/> Never Done: <input type="checkbox"/>						
Last Pap Test – Date: History of Abnormal Pap Tests: Unable to assess: <input type="checkbox"/> Never Done: <input type="checkbox"/>						
Other, not already listed above: <input type="checkbox"/> Further Assessment Deferred to GYN Clinic						
C. PHYSICAL EXAMINATION						
1. VITAL STATISTICS AND SIGNS						
Height:	Weight:	Temp:	BP:	Pulse:	Resp:	Oxygen Saturation:
BMI:	Waist Circumference:	Pain Rating:	/10		Location: (Enter details above under A. Medical History)	
2. GENERAL DESCRIPTION (e.g., appearance of health or distress, apparent vs. stated age, ability to give History reliably, mood, state of alertness/awareness, speech)						

Describe:			
3. SKIN, HAIR AND NAILS (check those that are abnormal and describe; note inability to assess and refusals)			
<input type="checkbox"/> No Abnormal Findings			
<input type="checkbox"/> Moisture	<input type="checkbox"/> Texture	<input type="checkbox"/> Nails	<input type="checkbox"/> Nodules
<input type="checkbox"/> Pigment	<input type="checkbox"/> Eruption	<input type="checkbox"/> Bruises	<input type="checkbox"/> Scars
<input type="checkbox"/> Hair	<input type="checkbox"/> Tattoos	<input type="checkbox"/> Ecchymoses	<input type="checkbox"/> Petechia
Describe:			
4. EYES (check those that are abnormal and describe; note inability to assess and refusals) For Visual Acuity and Other, see Neurological Exam Section 19.			
<input type="checkbox"/> No Abnormal Findings (assessed including fundi)			
<input type="checkbox"/> Lid-Lag	<input type="checkbox"/> Sclera	<input type="checkbox"/> Pupil	<input type="checkbox"/> Nystagmus
<input type="checkbox"/> Corneas	<input type="checkbox"/> Exophthalmos	<input type="checkbox"/> Conjunctiva	<input type="checkbox"/> Ptosis
<input type="checkbox"/> Fundi	<input type="checkbox"/> Unable to assess fundi, referred to Eye Clinic		
Describe:			
5. EARS (check those that are abnormal and describe; note inability to assess and refusals)			
<input type="checkbox"/> No Abnormal Findings (audiometric screening done separately)			
<input type="checkbox"/> Drums	<input type="checkbox"/> Hearing	<input type="checkbox"/> Discharge	<input type="checkbox"/> Mastoid Tenderness
Describe:			
6. NOSE (check those that are abnormal and describe; note inability to assess and refusals)			
<input type="checkbox"/> No Abnormal Findings			
<input type="checkbox"/> Airways	<input type="checkbox"/> Mucosa	<input type="checkbox"/> Septum	<input type="checkbox"/> Sinus Tenderness
Describe:			
7. MOUTH AND PHARYNX (check those that are abnormal and describe; note inability to assess and refusals)			
<input type="checkbox"/> No Abnormal Findings			
<input type="checkbox"/> Lip	<input type="checkbox"/> Salivary Ducts	<input type="checkbox"/> Gums	<input type="checkbox"/> Tongue
<input type="checkbox"/> Teeth	<input type="checkbox"/> Palate	<input type="checkbox"/> Tonsils	<input type="checkbox"/> Oropharynx
Describe:			
8. HEAD AND NECK (check those that are abnormal and describe; note inability to assess and refusals)			
<input type="checkbox"/> No Abnormal Findings			
<input type="checkbox"/> Shape	<input type="checkbox"/> Symmetry	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Vessels	<input type="checkbox"/> Masses	<input type="checkbox"/> Trachea	<input type="checkbox"/> Bruit
Describe:			
9. LYMPH NODES (check those that are abnormal and describe; note inability to assess and refusals)			
<input type="checkbox"/> No Abnormal Findings			
<input type="checkbox"/> Cervical	<input type="checkbox"/> Occipital	<input type="checkbox"/> Supraclavicular	
<input type="checkbox"/> Axillary	<input type="checkbox"/> Inguinal	<input type="checkbox"/> Other	
Describe:			
10. CHEST AND LUNGS (check those that are abnormal and describe; note inability to assess and refusals)			
<input type="checkbox"/> No Abnormal Findings			
<input type="checkbox"/> Shape	<input type="checkbox"/> Symmetry	<input type="checkbox"/> Respiratory Rate/Rhythm	
<input type="checkbox"/> Percussion	<input type="checkbox"/> Breath Sounds	<input type="checkbox"/> Adventitious Sounds, Other	
Describe:			
11. BREASTS (check those that are abnormal and describe; note inability to assess and refusals)			
<input type="checkbox"/> No Abnormal Findings		<input type="checkbox"/> Deferred to GYN Clinic	
<input type="checkbox"/> Asymmetry, Peau	<input type="checkbox"/> Nipples: Discharge,	<input type="checkbox"/> Tenderness	<input type="checkbox"/> Masses, Other

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d'Orange, Other Visual	Other		
Describe:			
12. HEART (check those that are abnormal and describe; note inability to assess and refusals)			
<input type="checkbox"/> No Abnormal Findings			
<input type="checkbox"/> Rate	<input type="checkbox"/> Rhythm	<input type="checkbox"/> Abnormal Heart Sounds	<input type="checkbox"/> Other Abnormalities
Describe:			
13. BLOOD VESSELS (check those that are abnormal and describe; note inability to assess and refusals)			
<input type="checkbox"/> No Abnormal Findings			
<input type="checkbox"/> Pulses	<input type="checkbox"/> Venous Abnormalities	<input type="checkbox"/> Other	
Describe:			
14. ABDOMEN (check those that are abnormal and describe; note inability to assess and refusals)			
<input type="checkbox"/> No Abnormal Findings			
<input type="checkbox"/> Contour	<input type="checkbox"/> Scars	<input type="checkbox"/> Tenderness	<input type="checkbox"/> Spasm/Rigidity
<input type="checkbox"/> Masses/Organomegaly	<input type="checkbox"/> Fluid	<input type="checkbox"/> Hernia	<input type="checkbox"/> Bowel Sounds
Describe:			
15. FEMALE GENITALIA (check those that are abnormal and describe; note inability to assess and refusals)			
<input type="checkbox"/> Not applicable (Male)	<input type="checkbox"/> No Abnormal Findings on Pelvic	<input type="checkbox"/> Deferred to GYN Clinic	
<input type="checkbox"/> External	<input type="checkbox"/> Vagina	<input type="checkbox"/> Cervix	<input type="checkbox"/> Uterus
<input type="checkbox"/> Adnexa	<input type="checkbox"/> Rectovaginal	<input type="checkbox"/> Discharge	<input type="checkbox"/> Scars, Other Lesions
Describe:			
16. MALE GENITALIA (check those that are abnormal and describe; note inability to assess and refusals)			
<input type="checkbox"/> Not applicable (Female)	<input type="checkbox"/> No Abnormal Findings	<input type="checkbox"/> Deferred to be done by:	
<input type="checkbox"/> External	<input type="checkbox"/> Penis	<input type="checkbox"/> Scrotum and Testicles	<input type="checkbox"/> Inguinal Hernia
<input type="checkbox"/> Lesions	<input type="checkbox"/> Discharge	<input type="checkbox"/> Other, Specify:	
Describe:			
17. RECTAL (check those that are abnormal and describe. For females, see also Rectovaginal exam in section 15, above; select option if not performed)			
<input type="checkbox"/> No Abnormal Findings	<input type="checkbox"/> Refused	<input type="checkbox"/> Deferred to be done by:	<input type="checkbox"/> Not indicated (explain):
<input type="checkbox"/> Fissure	<input type="checkbox"/> Fistula	<input type="checkbox"/> Sphincter	<input type="checkbox"/> Feces
<input type="checkbox"/> Masses	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Prostate (Male; Required Over Age 40)	
Describe:			
18. MUSCULOSKELETAL AND EXTREMITIES (check those that are abnormal and describe; note inability to Assess and refusals. For Tremor, sensory, and motor; see Neurological exam section 19.)			
<input type="checkbox"/> No Abnormal Findings			
<input type="checkbox"/> Redness, other Color	<input type="checkbox"/> Deformities/Amputations	<input type="checkbox"/> Clubbing	
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Varicosities	<input type="checkbox"/> Edema	
<input type="checkbox"/> Range of Motion	<input type="checkbox"/> Tenderness	<input type="checkbox"/> Other	
19. NEUROLOGICAL (check whether normal or abnormal, describe abnormal findings. Enter visual acuity.)			
a. Cranial Nerve Examination:			
Olfactory: Smell (specify scent used):		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal:
Distance Visual Acuity (Measured):		Near Vision if Tested:	
/	Right / Left		
/	Both Eyes	Strabismus: <input type="checkbox"/> L <input type="checkbox"/> R:	

Corrected <input type="checkbox"/>	Uncorrected <input type="checkbox"/>	None <input type="checkbox"/>
EOM: <input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal:	PERRLA: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:
Ptosis: <input type="checkbox"/> No	<input type="checkbox"/> Yes	Jaw Muscles: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:
Nystagmus: <input type="checkbox"/> No	<input type="checkbox"/> Yes	Closure of Eyes: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:

Facial Muscle Asymmetry:	<input type="checkbox"/> No	<input type="checkbox"/> Yes:
Gag Reflex: <input type="checkbox"/> Yes	<input type="checkbox"/> No:	Uvula Rises on Phonation: <input type="checkbox"/> Yes <input type="checkbox"/> No
Head Movement and Shrug of Shoulder:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal:
Tongue Protrusion Midline:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

b. Cerebellar Function Examination:

Finger-to-Nose <input type="checkbox"/> Yes <input type="checkbox"/> No: Intact:	Gait <input type="checkbox"/> Yes <input type="checkbox"/> No: Normal:
Heel-to Shin <input type="checkbox"/> Yes <input type="checkbox"/> No: Coordination Intact:	Romberg: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal:

c. Motor System Examination:

Muscle Atrophy: <input type="checkbox"/> No <input type="checkbox"/> Yes:	Abnormal Motor <input type="checkbox"/> No <input type="checkbox"/> Yes: Movements:
Muscle Weakness <input type="checkbox"/> No <input type="checkbox"/> Yes	/5 Strength

d. Sensory Examination:

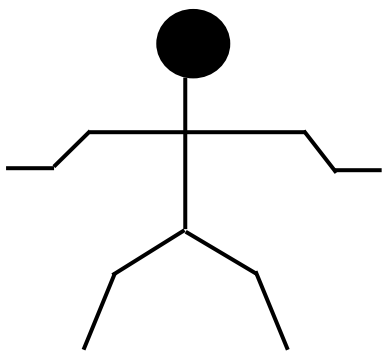
Light Touch Sensation Intact?	Pin Prick Intact?
UE: <input type="checkbox"/> Yes <input type="checkbox"/> No Face: <input type="checkbox"/> Yes <input type="checkbox"/> No	UE: <input type="checkbox"/> Yes <input type="checkbox"/> No Face: <input type="checkbox"/> Yes <input type="checkbox"/> No
LE: <input type="checkbox"/> Yes <input type="checkbox"/> No Trunk: <input type="checkbox"/> Yes <input type="checkbox"/> No	LE: <input type="checkbox"/> Yes <input type="checkbox"/> No Trunk: <input type="checkbox"/> Yes <input type="checkbox"/> No

Description of Sensory Abnormalities, Including Other (Vibratory, etc.):

e. Cognitive Observations, Orientation/Alertness: Tendon Reflex Examination:

<input type="checkbox"/> No abnormalities detected:	<input type="checkbox"/> Abnormal:
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f. Tendon Reflex Examination:

	Description of abnormal or asymmetrical findings:							
	<table border="1"> <tr> <td>Babinski Sign:</td> <td>Absent <input type="checkbox"/></td> <td>Present <input type="checkbox"/></td> </tr> <tr> <td>Other Pathological Reflexes:</td> <td>No <input type="checkbox"/></td> <td><input type="checkbox"/> Yes:</td> </tr> </table>	Babinski Sign:	Absent <input type="checkbox"/>	Present <input type="checkbox"/>	Other Pathological Reflexes:	No <input type="checkbox"/>	<input type="checkbox"/> Yes:	
Babinski Sign:	Absent <input type="checkbox"/>	Present <input type="checkbox"/>						
Other Pathological Reflexes:	No <input type="checkbox"/>	<input type="checkbox"/> Yes:						

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g. Description of Checked Abnormal Neurological Findings Not Entered Above, Portions Not Able to Assess, and Refusals:

Describe if "Yes":

D. ASSESSMENT AND PLAN

DIAGNOSTIC IMPRESSION	DIAGNOSIS AND TREATMENT MEASURES INITIATED AT THIS TIME	RECOMMENDED TREATMENT AND FOLLOW-UP FOR CONSIDERATION BY UNIT PHYSICIAN'S, NOT ORDERED AT THIS TIME

E. Is There an acute medical issue(s) that requires attention at this time?

No Yes

Describe if "Yes":

F. Further Plan of Care, Preventive Health Screening and Health Maintenance:

Interventions and follow-up that should be addressed by the unit Program Medical Consultant and Psychiatrist (Check all that apply or are indicated):

- Monitor monthly or more frequently if indicated: Height, Weight, Temperature, BP, Pulse, Respiratory Rate, Oxygen Saturation, Pain Rating, BMI, and WC
- Counseling regarding Smoke Cessation and increase risk of complications
- Counseling regarding overweight or obesity, the need to watch diet, exercise and the increased risk of obesity related complications
- Admission's Laboratory Tests that include: UA, CBC, fasting Comprehensive Metabolic Panel (Glucose, electrolytes, BUN and Creatinine) and Lipid Panel (Total Cholesterol, HDL, LDL, and TG), Calcium, Phosphorus, Lipase, Amylase, TSH, Prolactin, Hepatitis B surface antigen and antibody, Hepatitis C antibody, Measles, Rubella and Varicella titers and RPR. Urine pregnancy test for female individuals Under 50 years old and no contraindications.
- Vitamin D level

- Vitamin B-12 level
- HIV Antibody Test (Test according to Special Order 104.02)
- Sickle Cell Test (FOR INDIVIDUAL OF AFRICAN AMERICAN OR MEDITERRANEAN GENETIC ORIGIN WITHOUT PREVIOUS DOCUMENTED TEST)
- 1-Step PPD Test
- 2-Step PPD Test
- PPD is contraindicated because: _____
- Chest X-Ray: PA view
- Chest X-Ray: PA & Lateral Views
- EKG
- Tetanus-Diphtheria acellular Pertussis (Tdap) vaccine
- Flu (Influenza) vaccine as available during flu season and if not contraindicated.
- Pneumococcal vaccine
- Colorectal Cancer Screening
- PSA Blood Test
- Chlamydia and Gonococcal testing
- PAP smears
- Breast Cancer Screening with Clinical Breast Examinations (CBE) FOR FEMALE INDIVIDUALS 20 YEARS OR OLDER
- Breast Cancer Screening with Mammography
- Bone Mass Density (BMD) Test:

G. REFUSALS (Documented Unsuccessful Efforts to Obtain Cooperation with Admission History and Physical Assessment. All refusals must be referred to the unit physicians via physician's order in the chart.)

Completed By:

Print Name: _____

Signature: _____

Date: _____

Countersigned By (Physician Co-signature Required for Nurse Practitioner or Medical Student/Resident Exams):

Print Name: _____

Signature: _____

Date: _____