



- SURGERY FACULTY PRACTICE
- VASCULAR SURGERY FACULTY PRACTICE
- ORTHOPEDIC FACULTY PRACTICE
- CARDIOVASCULAR THORACIC & TRANSPLANT SURGERY FACULTY PRACTICE

Line up Patient I.D. Label Here

HEALTH RECORD

Date _____ Completed by: <input type="checkbox"/> Patient <input type="checkbox"/> Other _____ Reason for visit: <input type="checkbox"/> Follow-up visit <input type="checkbox"/> Problem (please list) _____	For Clinical Staff: Initial if physician review required
PLEASE COMPLETE THE FOLLOWING SECTIONS AS FULLY AS POSSIBLE:	
Adult Vaccines: Have you had any of the following vaccines?	
Hepatitis B Series <input type="checkbox"/> No <input type="checkbox"/> Yes/Year #1____ #2____ #3____ Flu <input type="checkbox"/> No <input type="checkbox"/> Yes/Year _____ Pneumococcal <input type="checkbox"/> No <input type="checkbox"/> Yes/Year _____ Tetanus <input type="checkbox"/> No <input type="checkbox"/> Yes/Year _____	
Have you (or anyone that lives in the same household as the patient) had any of the following:	
1. A history of MRSA or VRE infection? <input type="checkbox"/> No <input type="checkbox"/> Yes: Treated? _____ When? _____ 2. Recent exposure to chicken pox, shingles, scabies or lice? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ 3. Any other infectious (contagious) disease? <input type="checkbox"/> No <input type="checkbox"/> Yes _____	
TUBERCULOSIS (TB) SCREENING - Check the box if the answer is YES. If the answer is NO, leave blank	
<input type="checkbox"/> Cough for longer than 2 weeks [3] <input type="checkbox"/> History of TB or active TB (even if on meds) [5] <input type="checkbox"/> Blood in the sputum [5] <input type="checkbox"/> Jail in the past two years [2] <input type="checkbox"/> Fevers or night sweats [2] <input type="checkbox"/> HIV positive [2] <input type="checkbox"/> Recent unexplained weight loss of > 10 lbs [2] <input type="checkbox"/> Homeless or living in a shelter [1] <input type="checkbox"/> Recent exposure to TB [2] <input type="checkbox"/> Foreign born (Asia, E. Europe, Latin America, Africa) [1]	
USE OF TOBACCO PRODUCTS	
Do you smoke or use tobacco products of any kind? <input type="checkbox"/> No <input type="checkbox"/> Yes* If patient is a minor and does not smoke, does anyone living in the house with the patient smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Would you like to receive information on how to stop using tobacco products? <input type="checkbox"/> No <input type="checkbox"/> Yes	
PSYCHOSOCIAL SCREENING:	
Do you have any behavioral and/or mental health concerns? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Do you have any special religious and/or spiritual needs? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Is there any history of or current sexual, emotional, or physical abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Is there any history of or current domestic violence? <input type="checkbox"/> No <input type="checkbox"/> Yes _____	
FALLS ASSESSMENT (ADULT) (Check all boxes that apply)	
<input type="checkbox"/> Do you have any problems with your vision? <input type="checkbox"/> Have you ever fallen due to a medical problem? If yes, when? _____ <input type="checkbox"/> Do you have any heart problems? <input type="checkbox"/> Do you have any weaknesses in your muscles that may cause you to fall? <input type="checkbox"/> Do you have any breathing problems? <input type="checkbox"/> Do you take any medicines that make you feel dizzy? Do you use any of the following: <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Pacemaker <input type="checkbox"/> Crutches <input type="checkbox"/> Glasses/Contacts <input type="checkbox"/> Walker <input type="checkbox"/> Leg Braces <input type="checkbox"/> A/B Monitor <input type="checkbox"/> Wheelchair <input type="checkbox"/> _____	
ADVANCE DIRECTIVES - (COMPLETE ONLY IF OLDER THAN 18)	
Do you have a Healthcare Surrogate? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you have it with you? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you have a Living Will? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you have it with you? <input type="checkbox"/> No <input type="checkbox"/> Yes	
For Office Use	
Nursing/MOA Review: _____ Title _____ Date _____ Time _____ Physician/Practitioner: _____ I.D.# _____ Date _____ Time _____	

TO BE COMPLETED BY OFFICE STAFF

Nursing/MOA Staff: Place your initials next to any “Yes” answers that require physician review

INSTRUCTIONS

IMMUNIZATIONS	If current per parent/guardian, verify on Vaccine Administration Record (VAR) (General Pediatrics Only)
CONTAGIOUS DISEASES	If “Yes” to any of these notify clinical staff immediately so an RN or physician can triage to determine possible transmission risk.
IF A HISTORY OF MRSA/VRE	Initiate MRSA/VRE Protocol orders #5872-96739
TUBERCULOSIS (TB) SCREENING	<p>Pediatric [younger than 12] – if “Yes” to this, notify clinical staff immediately so an RN or physician can triage to determine possible transmission risk.</p> <p>Adults [12 and older] – add up points:</p> <p>Total points _____</p> <p>If the patient has received 5 or more points, place a TB mask on the patient and place in a private room, using Airborne precautions. Contact the physician for an assessment.</p>
USE OF TOBACCO PRODUCTS	If a patient answers yes to: “Would you like to receive information on how to stop using tobacco products?” Offer the TIPS TO KICK TOBACCO booklet through Smartworks (4767-46341).
PSYCHOSOCIAL SCREENING	<p>Any “Yes” answer must be addressed. Refer to Corporate P&P that details the requirements for healthcare workers.</p> <p>SUSPECTED CHILD, ELDERLY, OR MENTALLY HANDICAPPED ABUSE OR NEGLECT: IDENTIFICATION AND REPORTING #1600</p> <p>SUSPECTED DOMESTIC VIOLENCE REPORTING (ADULT) #1625</p> <p>Abuse Hotline: 1-800-96-ABUSE</p>
FALLS ASSESSMENT	If any special assist devices are checked, patient is increased risk for falls. Make sure the environment is safe and free of obstructions.