

**Nursing History - Patient Profile** 

## \*An Patrite & t »

«AdmitDate» ECD #: «PatientNumber»

«PatientName»

MR#: «MedicalRecordNumber» LOC: «Location» «Room» «Bed»

«AttendingDoctorName» DOB: «BirthDate»

<u>General Information</u>
How to be addressed
Spoken Language Preferred □ English □ Spanish □ Chinese □ Filipino □ French □ German □ Italian □ Korean □ Russian □ Sign □ Vietnamese □ Other
Reading Language Preferred □ English □ Spanish □ Chinese □ Filipino □ French □ German □ Italian □ Korean □ Russian □ Sign □ Vietnamese □ Other
Parental Spoken Language Preferred □ English □ Spanish □ Chinese □ Filipino □ French □ German □ Italian □ Korean □ Russian □ Sign □ Vietnamese □ Other
Parental Reading Language Preferred       □ English       □ Spanish       □ Chinese       □ Filipino       □ French       □ German         □ Italian       □ Korean       □ Russian       □ Vietnamese       □ Other
<b>Source of information</b> □ patient □ family □ significant other □ acute care facility □ chart(s) □ extended care facility □ foster care □ physician office □ inpatient rehabilitation facility □ unable to respond/no family available □ other
Admitted From ☐ home ☐ acute care hospital ☐ ambulatory surgical center ☐ clinic ☐ correctional facility ☐ ED ☐ physician office ☐ referring hospital ☐ rehab facility ☐ residential facility ☐ school ☐ skilled nursing facility ☐ other
General Info Comment
Body Measurements/Pain
Birth Weight (kg) (grams) (pounds) (ounces)

**Expression of Pain** □ activity pattern change □ aggression □ agitated □ anorexia □ anxious □ arched/rigid □ body stiffness □ clenching teeth/lips □ contracted limbs □ crying □ eyes wide open □ flailing □ grimace □ jerking □ moaning □ muscle tension □ restless □ rocking □ rubbing □ sleep pattern change □ squirming

Chronic Pain? Yes/No If Yes: description of pain (frequency/quality) □ constant □ frequent □ intermittent □ occasional □ aching □ burning □ cramping □ crushing □ gnawing □ pressure □ prickling □ radiating

☐ sharp ☐ soreness ☐ spasm ☐ stabbing ☐ throbbing ☐ tightness ☐ tingling ☐ other

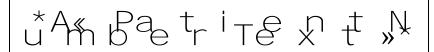
EW #2437 / LD #213610 - Rev. 9/30/20

□ verbal □ withdrawn

Chronic Pain Duration\_\_\_



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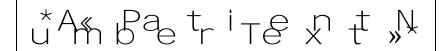
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Body Measurements/Pain (chronic pain continued)
(only answer if yes to chronic pain above)  Factors that Aggravate Pain □ activity □ breathing □ eating □ not eating □ environmental □ family not present □ fear □ ineffective pain medication □ inactivity □ movement □ palpation □ positioning □ stimulation □ other
Factors that Relieve Chronic Pain □ acupuncture □ chiropractic □ cold □ distraction □ environment adjustment □ exercises □ heat □ imagery □ immobilization □ massage □ medication □ meditation □ music □ relaxation □ repositioning □ rest □ splinting □ transcutaneous electric nerve stimulator □ other
Roles/Relationships
Where does the patient live? ☐ family home ☐ foster home ☐ long-term care facility ☐ other
Lives With □ mother □ father □ mother and partner □ father and partner □ stepmother □ stepfather □ grandmother □ grandfather □ aunt □ uncle □ sister □ brother □ host family □ foster family □ legal guardian □ other
For patients under 12 months (365 days), where does your baby sleep at home? □ crib □ bassinet pack and play □ couch □ chair □ other (specify)
Do you have a crib or a pack and play for your baby to sleep in?   Yes In No (If no, please contact Social Work)
<b>Primary Caregiver</b> □ mother □ father □ grandmother □ grandfather □ aunt □ uncle □ sister □ brother □ host family □ foster family □ legal guardian □ other
Who has legal custody of the patient? ☐ parents ☐ mother ☐ father ☐ grandparent(s) ☐ aunt ☐ uncle ☐ foster family ☐ DHR (notify Social Services) Specify Name of Legal Custodian
Court Ordered Visitation? Yes/No If Yes, copy on Chart? Yes/No Visitation schedule
<b>Limitations on Visitors/Phone Calls</b> □ none □ immediate family may visit □ spouse may visit □ spouse may visit □ significant other/partner may visit □ no visitors □ no phone calls □ no release of information □ other
Patient/Primary Caregiver would like a support person to be notified of patient admission □ no □ yes
Does the patient have a DHR caseworker? Yes/No If Yes, notify social services.  If Yes, specify the name and county
Health and Illness
Reason for your Admission as Stated by Patient/Parent/Caregiver
Primary Care Physician Specialty Physician/Others
Legal Guardian requests to opt out of primary care physician notifications? ☐ no ☐ yes
Case Manager/Sponsor
Services Anticipated at Discharge □ none □ specialized car seat (notify Patient Health and Safety/COA House Officer for car seat fitting) □ education services □ extended care facility □ home health care □ hospice care □ inpatient rehabilitation facility □ mental health services □ outpatient hemodialysis □ outpatient peritoneal dialysis □ outpatient rehabilitation □ skilled nursing facility □ support groups □ other
Anticipated Discharge Disposition □ home □ home with assist □ home with home health □ home with hospice □ home with outpatient services □ extended care facility □ foster/protective services □ inpatient hospice □ inpatient rehabilitation facility □ shelter □ street □ other
Person Authorized to Receive Patient on Discharge
Patient Aware of Diagnosis



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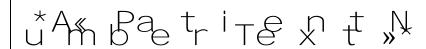
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Immunization History
Are Immunizations Up to Date? ☐ yes ☐ no Verified by: ☐ mother ☐ father ☐ grandparent ☐ caregiver ☐ foster parent ☐ medical record ☐ other
<b>Recent exposure</b> □ none □ exposure to chicken pox within last month □ exposure to measles within last month □ exposure to mumps within last month □ exposure to TB within last 3 months □ exposure to pertussis within last month □ other
Present on Admission
Vascular Access Device       □ yes       □ no       Side location       □ left       □ right       □ bilateral       Insertion Date         Type       □ CVL       □ chronic dialysis catheter       □ implanted port       □ midline catheter       □ PIV       □ PICC
<b>Urinary Device</b> □ none □ indwelling urethral catheter □ suprapubic catheter □ urinary diversion □ intermittent catheterization □ Insertion Date/Last Catheterization Time
Pressure Injury(s) on Admission □ yes □ no Number of Pressure Injury(s)/Location(Remember to document Plan of Care and page WOCRN)
Special Needs
<b>Does the patient have a cognitive impairment?</b> □ yes □ no <b>If yes,</b> □ difficulty remembering □ difficulty making decisions □ developmental delay
<b>Visual Impairment?</b> ☐ yes ☐ no <b>If yes,</b> ☐ blindness, left eye ☐ blindness, right eye ☐ serious difficulty, left eye ☐ serious difficulty, right eye <b>Patient relies on the following visual devices:</b> ☐ glasses ☐ contacts ☐ other
<b>Hearing impairment?</b> ☐ yes ☐ no <b>If yes,</b> ☐ deafness, left ear ☐ deafness, right ear ☐ serious difficulty, left ear ☐ serious difficulty, right ear <b>Patient relies on the following for hearing:</b> ☐ hearing aid ☐ sign language ☐ lip reading ☐ cochlear implants ☐ other
Does the patient have a current medical condition that places them at risk and causes problems with mobility?  ☐ yes ☐ no If yes, ☐ difficulty walking ☐ difficulty climbing up stairs ☐ difficulty climbing down stairs Patient relies on the following equipment ☐ wheelchair ☐ walker ☐ crutches ☐ cane ☐ other
Does the patient have current medical condition/diagnosed condition that places them at risk for difficulty eating, playing, using hands, and or self care? $\square$ yes $\square$ no If yes, $\square$ difficulty bathing $\square$ difficulty dressing $\square$ difficulty running errands alone
Is patient currently having difficulty with speech, communicating, or with swallowing? ☐ yes ☐ no If yes, as evidenced by ☐ observation ☐ parent report ☐ risk due to condition
Patient currently using home medical equipment? ☐ yes ☐ no If yes, ☐ oxygen ☐ feeding pump ☐ infusion pump ☐ apnea monitor ☐ nebulizer ☐ ventilator ☐ other
General Medication Information
Medication Patch/Pump       □ none       □ medication patch(es) used (specify)         □ medication pump(s) used (specify)
Anything Interfering with Ability to Follow Medication Schedule □ none □ age □ inability to prepare and administer dose correctly □ lack of knowledge regarding managing health concern □ lack of knowledge regarding medication purpose □ medication side effects □ unable to afford medications □ other





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General Medication Information (continued)					
Herbal Remedies ☐ yes ☐ no If yes, ☐ echinacea ☐ fever few ☐ garlic ☐ ginger ☐ ginkgo ☐ goldenseal ☐ kava-kava ☐ licorice ☐ ma-huang (ephedra) ☐ saw palmetto ☐ St. John's Wart ☐ valerian ☐ other					
Important Medication Experience/Information/Administration Techniques □ no concerns □ administer in food □ crush pills for administration □ cut pills in half □ difficulty swallowing pills □ requires elixir form □ other					
Current Medications □ none □ unable to obtain					
Current Medication (When EHR is available, enter current medications in Outpatient Medication Review)	Dose	Frequency	Last dose taken		
Allergies/Intolerances (When EHR is available, ensure Allergies have been entered)  Allergies/Intolerances □ none □ unable to obtain					
Allergies/Intolerances		Reaction			
Previous Hospitalizations and Surgeries					
Previous hospitalizations/surgeries? □ yes □ no If yes, *Year/Reason					
*Year/Reason					
*Year/Reason					



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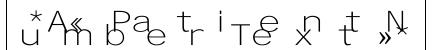
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Family History
· <del></del>
Risk Screens
Columbia-Suicide Severity Scale (displayed for greater than 5 years of age) (Questions relate to past month)  Does this patient have a primary complaint that is emotional or behavioral in nature?
Sensory Risk  Does the patient meet sensory alert? ☐ yes ☐ no ☐ unable to assess  If unable to assess, Why can Sensory Alert Not be assessed? ☐ medically unstable ☐ trauma patient ☐ family not available ☐ unresponsive ☐ Other (please specify)
If Yes, Is your child sensitive/avoidant to the following: □ visual stimulation (lights, videos, etc) □ auditory stimulation (certain sounds, music, etc) □ smells □ touch/textures □ Other (please specify)
If Yes, Does your child enjoy/seek stimulation from any of the following: □ visual stimulation (lights, videos, etc) □ auditory stimulation (certain sounds, music, etc) □ smells □ touch/textures □ Other (please specify)
If Yes, How does your child prefer to communicate? □ verbal □ nonverbal □ communication device:
If Yes, Your child learns best by: ☐ seeing (visual) ☐ hearing (auditory) ☐ touching and exploring (tactile) ☐ Other (please specify)
If Yes, Specific triggers or things that may upset your child:
If Yes, Specific behaviors your child may exhibit when upset or becoming upset:
If Yes, What helps your child calm down (comfort items, coping, techniques, etc)?
If Yes, Dominant Hand □ right □ left
Functional Age: (example: 8 years old but functions on a 2 year old's level)



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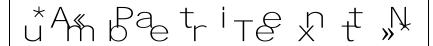
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<u>Clinical Nutrition</u>
Patient is on an altered feeding regimen, specialized formula, modified diet, food allergies, tube-feedings or TPN at home    yes   no  If yes, specify and notify nutrition services
Patient diagnosed with chronic illness having nutritional impact □ yes □ no If yes, specify and notify nutrition services
Is patient taking Warfarin/Coumadin at home? ☐ yes ☐ no If yes, notify nutrition services
<b>Ethnic/Religious Diet Preferences?</b> □ yes □ no <b>If yes, notify nutrition services</b> □ Kosher □ strict Kosher □ no pork □ no beef □ no caffeine □ no shellfish □ other
<u>Lactation</u>
<b>Is the patient lactating?</b> □ yes (notify lactation services) □ no
Is the patient fed with breast milk? ☐ yes ☐ no
Is the mother lactating for patient/siblings? □ yes (offer/order pump equipment) □ no
Patient's mother has lactation concerns? ☐ yes (notify lactation services) ☐ no
Values/Beliefs/Practices (FICA)
F) Faith: What cultural, spiritual, or religious beliefs/practices are important for us to know?
I) Influence: How will these beliefs/practices influence your health care decisions?
C) Community: Are you part of a cultural, spiritual, or religious community/and is it supportive?
A) Address: How would you like for the health care team to address these values/beliefs/practices?
Substance Exposure/Use
Does your child have any caretakers who smoke cigarettes? ☐ yes ☐ no If yes, ☐ family member who lives with patient (specify) ☐ family member who does not live with patient (specify) ☐ friend or other caretaker (specify) ☐ If yes, How often is your child with caretakers who smoke cigarettes? ☐ daily ☐ 2-4 times per week ☐ 4 or more times per week ☐ 2-3 times per month ☐ monthly or less ☐
Do you allow smoking inside of your house or car? ☐ yes ☐ no ☐ n/a
Patient's Smoking Status □ never smoker □ unknown if ever smoked □ *smoker, current status unknown □ *former smoker □ *current every day smoker □ *current some day smoker □ *light tobacco smoker □ *heavy tobacco smoker
Is smoker, type of tobacco □ cigarettes □ cigars □ pipe □ hookah tobacco □ e-cigarettes  Previous treatment □ yes □ no Smoking Cessation Program Interest □ yes □ no Instructed on no smoking policy □ yes □ no
Patient's Chewing Tobacco Use ☐ never ☐ current ☐ past If current/past, ☐ occasional use ☐ 1-2 tins/week ☐ 2-4 tins/week ☐ 5 or more tins/week Attempts to Quit Tobacco Use, ☐ none ☐ antidepressant ☐ counseling ☐ bypnosis ☐ nicotine replacement therapy ☐ quit on own ☐ tobacco cessation program



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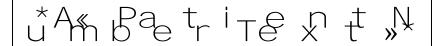
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Substance Exposure/Use
Patient's Alcohol Use ☐ never ☐ current ☐ past If current/past, alcohol last use  If current/past, Alcohol Amount ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7-9 drinks ☐ 10 or more drinks  Alcohol Frequency ☐ monthly or less ☐ 2-4 times/month ☐ 2-3 times/wee ☐ 4 or more times/week ☐ daily  Alcohol Type ☐ beer ☐ wine ☐ liquor Use duration ☐ Readiness to Quit ☐ not  motivated to quit ☐ thinking about quitting ☐ ready to quit ☐ refuses to discuss Attempts to Quit Alcohol ☐ none  ☐ Alcoholics Anonymous ☐ counseling ☐ detox unit ☐ outpatient treatment ☐ quit on own ☐ residential treatment  ☐ support group Method of Quitting ☐ not motivated to quit ☐ thinking about quitting ☐ ready to quit ☐ refuses to discuss
Patient's Street Drug/Inhalent/Medication Use □ street drug/inhalents/medication never used □ street drug/inhalant/medication abuse current □ street drug/inhalant/medication abuse past  If current/past, Type □ amphetamines □ cocaine □ depressants □ ecstasy □ hallucinogens □ heroin □ inhalents (solvents, gases, nitrites, aerosols) □ marijuana □ mescaline □ methamphetamine □ narcotics □ PCP (phencyclidine) □ sedatives □ steroids □ stimulants  Route □ intravenous □ oral □ smoking □ snorting □  Duration □ Quantity Consumed □ unknown □ amount (specify) □
Psychiatric History (Psychiatric Patients Only)
Responsible relative/guardian
Patient Search □ no □ yes (if yes, by whom?)
Patient has been oriented to ☐ room ☐ visiting policy ☐ inappropriate/appropriate items for patients ☐ meal times ☐ bed times ☐ patient rights ☐ use of restraint and seclusion
Family has been oriented to □ room □ visiting policy □ inappropriate/appropriate items for patients □ meal times □ bed times □ patient rights □ use of restraint and seclusion
Details of Current Problem
Previous inpatient treatment □ none □ yes If yes, *Year/Reason
*Year/Reason
*Year/Reason
*Year/Reason
Prior inpatient comments





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<u>Psychiatric History (Psychiatric Patients Only)</u>
Previous outpatient treatment □ none □ yes  If yes, *Year/Reason
*Year/Reason
*Year/Reason
*Year/Reason
Prior outpatient comments
Any contraindications in use of restraint? □ no □ yes (if yes, specify)
Other alternatives prior to restraint/seclusion?   no  yes (if yes, specify)
Is there a history of Electro Convulsive Therapy (ECT)? □ no □ yes (if yes, specify)
Is there a history of eating disorder? □ no □ anorexia □ binging □ purging □ laxative dependent □ other
Is there a history of excessive exercise? □ no □ yes (if yes, specify frequency)
Assist Devices □ contacts □ glasses □ hearing aids □ walker □ wheelchair □ prosthesis □ mouth guard □ retainer □ other (specify)
Elimination pattern □ normal □ incontinence □ enuresis □ diarrhea □ constipation □ encopresis □ other
Sleep difficulty   no pes Bedtime Time Awakens
Child was born □ full term □ late □ early (specify how early)
Age at which patient was able to say words
Is the patient unable to follow commands or to express him/herself as well as expected for age? ☐ no ☐ yes (specify)
Do you own any weapons? ☐ yes ☐ no If yes, are firearms in locked area? ☐ yes ☐ no
Family Psychiatric History
Family Medical History