|  |  |  |
| --- | --- | --- |
| **رابطة الجامعين /محافظة الخليل** |  | **University Graduates Union** |
| **جامعة بوليتكنك فلسطين** | **Palestine Polytechnic University** |
| **كلية التمريض** | **College of Nursing** |
|  |  |

**Complete Health History:**

**Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_A B**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age: \_\_\_\_\_\_\_\_\_ Marital Status: S M D W**

**Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nationality : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Chief complain:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**History of Present Illness:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past Health History:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Medications:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family health History:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Functional assessment**

**Activity & Exercise:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nutrition and eating patterns:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Bathing/ dressing/ toileting/**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sleeping Pattern:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Coping/ Stress management**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Personal habits- smoking, alcohol, drugs**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Occupational/ environmental hazards**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Additional Comments:**

**Review of body system**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Review of Body Systems

1. Skin, Hair, Nail:

Skin

Subjective data

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| YES | NO |  | YES | NO |  |
| □ | □ | Body odor | □ | □ | History of skin disease |
| □ | □ | Itching/Rashes | □ | □ | Increased bruising |
| □ | □ | Scales, or flaking | □ | □ | Sores that do not heal |
| □ | □ | Change in mole | □ | □ | History of skin cancer |
| □ | □ | Itching/Rashes | □ | □ | Use of sun screen |
| □ | □ | Dry or oily skin | □ | □ | Lesions or infections |
| □ | □ | Hair loss | □ | □ | Change in skin color |
| □ | □ | Itching/Rashes | □ | □ | Environmental or occupational |
| □ | □ | Medications |  |  | hazards |

IF YES, Provide Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hair

Subjective Data

Yes NO

□ □ Changes in hair texture

□ □ Changes in hair distribution

□ □ Scalp irritation or itching

□ □ Scalp infection infestation

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nails

Subjective data

Yes No

□ □ Problems or changes in nails

□ □ Increased brittleness

□ □ Color or shape changes

□ □ Infections of the nails

□ □ Wear artificial nails

□ □ Biting or chewing nails

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Head (Hair, Scalp, and Face):

Subjective data

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| YES | NO |  |  | YES | NO |  |
| □ | □ | Hair problems / loss | | □ | □ | Headache |
| □ | □ | Itching or flaking scalp | | □ | □ | Fainting/dizziness |
| □ | □ | Scalp infection / lesions |  | □ | □ | Head injury |
| □ | □ | Seizure |  | □ | □ | Facial weakness |
| □ | □ | Facial pain or numbness |  | □ | □ | Facial swelling |

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Neck &Thyroid:

Subjective data

Yes NO Yes NO

□ □ Problems swallowing

□ □ Lumps or swelling

□ □ Neck pain, limitation of motion

□ □ Lump or thickness in throat

□ □ History of neck injury

□ □ History of thyroid problems

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Eyes and Vision:

Vision

Subjective data

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| YES | NO |  | YES | NO |  |
| □ | □ | Blurry vision | □ | □ | Floaters within visual field |
| □ | □ | Change in vision | □ | □ | Headaches related to vision |
| □ | □ | Double vision | □ | □ | Past history of ocular problems |
| □ | □ | Loss of vision | □ | □ | Gluacoma |
| □ | □ | Straining to see | □ | □ | Watering/discharge |
| □ | □ | Pain |  |  |  |

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Eyes

Subjective data

Yes NO Yes NO

□ □ Crusting or lesions eyelids

□ □ Redness of eyes

□ □ Drainage from around eye

□ □ Allergies

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Ears and Hearing:

Subjective data

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| YES | NO |  | YES | NO |  |
| □ | □ | Infections | □ | □ | Discharge from ears |
| □ | □ | Earache | □ | □ | Tinnitus |
| □ | □ | Discharge | □ | □ | Hearing problems |
| □ | □ | Medications | □ | □ | Dizziness |
| □ | □ | Otalgia | □ | □ | Environmental/occupational noise |
| □ | □ | Allergies | | | exposure |
| □ | □ | vertigo | □ | □ | If Yes: One or both ears |

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Nose, Mouth, Throat:

Nose

Subjective Data

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| YES | NO |  | YES | NO |  |
| □ | □ | Allergies | □ | □ | Nasal obstruction |
| □ | □ | Alter smell | □ | □ | Sinus infection/pain |
| □ | □ | Snoring | □ | □ | Use of nasal sprays |
| □ | □ | Discharge | □ | □ | Cold and or sneezing |
| □ | □ | Nosebleeds | □ | □ | Injury or surgery of nose |

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mouth

Yes NO Yes NO

□ □ Lesions or sores in mouth

□ □ Swollen or bleeding gums

□ □ Toothache

□ □ Difficulty chewing

□ □ Wear dentures

□ □ Bleeding gums

□ □ Bad breath □ □ Altered taste

□ □ Last Dental check-up Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Throat

Yes NO Yes NO

□ □ Hoarseness

□ □ Loss of voice

□ □ Dysphagia

□ □ frequent sore throats

□ □ frequent infections

□ □ Smoke cigarettes

□ □ Smoke pipe

□ □ Chew tobacco

□ □ Wear dentures

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Breasts and Axillae:

Subjective Data

Yes NO Yes NO

□ □ Breast disease

□ □ Pregnancies

□ □ Pain

□ □ Lymph node enlargement

□ □ Lymph node pain

□ □ Surgery, biopsy

□ □ lumps dimpling of the skin □ □ Rash

□ □ Nipple discharge □ □ Swelling

□ □ Hormonal medication □ □ Trauma

□ □ Breast self-examination

1. Respiratory System:

Subjective Data

Yes NO Yes NO

□ □ Allergies

□ □ Asthma, wheezing

□ □ Tobacco use

□ □ Medications

□ □ Cough

□ □ Sputum production

□ □ Orthpnea

□ □ Hemoptysis

□ □ Chest pain

□ □ Shortness of breath

□ □ Occupational risk factors

□ □ Environmental risk factors

□ □ Dyspnea □ □ Respiratory disease history

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Cardiovascular and Peripheral Vascular:
2. Cardiovascular:

Subjective Data

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| YES | NO |  | YES | NO |  |
| □ | □ | Cardiac disease | □ | □ | Chest pain or tightness |
| □ | □ | BP problems | □ | □ | Shortness of breath |
| □ | □ | Cough | □ | □ | Swelling ankles/legs/edema |
| □ | □ | Fatigue | □ | □ | Family cardiac history |
| □ | □ | Past cardiac history | □ | □ | Extra pillows when sleeping |
| □ | □ | Dyspnea / Orthopnea | □ | □ | personal habits (cardiac |
| □ | □ | Cold hands or feet |  |  | risk factors) |

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Peripheral Vascular:

Subjective Data

YES NO

□ □ Slow wound healing

□ □ Phlebitis

□ □ Swelling ankles or legs

□ □ Leg pain or cramps

□ □ Lymph nodes enlargement

□ □ Medications

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Abdomen and Gastrointestinal:

Subjective Data

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| YES | NO |  | YES | NO |  |
| □ | □ | Indigestion | □ | □ | Burping, increased gas |
| □ | □ | Heartburn | □ | □ | Change in bowel habits |
| □ | □ | Diarrhea | □ | □ | Fecal incontinence |
| □ | □ | Constipation | □ | □ | Routine use of laxatives |
| □ | □ | Color of stools | □ | □ | Nutritional assessment |
| □ | □ | Appetite | □ | □ | Flatulence or increased gas |
| □ | □ | Abdominal pain | □ | □ | Frequency of bowel movements |
| □ | □ | Nausea or vomiting | □ | □ | Past abdominal history |
| □ | □ | Difficulty swallowing |  |  |  |

Liver

YES No

□ □ Jaundice

□ □ Diarrhea

□ □ Color of urine & stools

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Musculoskeletal or Gait:

Subjective Data

Yes No Yes NO

□ □ Recent injury

□ □ Exercise

□ □ Muscle aches or pain

□ □ Skeletal aches or pain

□ □ Muscle weakness

□ □ Joint problems

□ □ Muscular disease

□ □ Neck pain / problem

□ □ Back pain / problem

□ □ Shoulder pain / problem

□ □ Elbow pain / problem

□ □ Hand pain/ problem

□ □ Hip pain / problem

□ □ Knee pain / problem

□ □ Ankle pain / problem

□ □ Foot pain / problem

□ □ Fracture history

□ □ musculoskeletal surgery

□ □ Scoliosis □ □ Deformity/Trauma

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Neurological:

Subjective Data

Yes NO Yes NO

□ □ Recent injury

□ □ Weakness

□ □ Numbness / tingling

□ □ Neurological pain

□ □ Shooting pains

□ □ Gait problems

□ □ Coordination problems

□ □ Dizziness

□ □ Headaches

□ □ Memory difficulties

□ □ Learning disorder

□ □ Seizures or convulsion

□ □ Head injuries □ □ Incoordination

□ □ Tremors □ □ Difficulty swallowing

□ □ Significant past history □ □ Difficulty speaking □ □ Environmental or occupational hazards

.IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Elimination:

Subjective Data

Yes No Yes NO

□ □ Anal or rectal bleeding

□ □ bright red / black tarry

□ □ Associated with BM

□ □ Hemorrhoids

□ □ Change in bowel habits

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Urinary:

Subjective Data

Yes NO YES NO

□ □ Frequent urination

□ □ Difficult or painful urination

□ □ Urinary incontinence

□ □ Difficulty starting urination

□ □ Dribbling following urination

□ □ Feeling bladder not emptied

□ □ Frequency

□ □ Hematuria

□ □ Incontinence

□ □ Infection □ □ Nocturia

□ □Urine color

IF YES, Provide Details

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature: Date: / /