

CENTRAL MONTANA MEDICAL CENTER
Lewistown, Montana

PHYSICAL ASSESSMENT SHEET

MR-55B

6/90, R10/98, 6/00, 1/02, 9/02, 10/02

FALL RISK FACTORS IN BOLD

ADDRESSOGRAPH

General Appearance:					
Having Pain Now? <input type="checkbox"/> Yes <input type="checkbox"/> No Rated Pain: 1 2 3 4 5 6 7 8 9 10 Time: _____					
Neurological <input type="checkbox"/> No Known Problem	<input type="checkbox"/> Oriented <input type="checkbox"/> Disoriented <input type="checkbox"/> Lethargic	<input type="checkbox"/> Comatose <input type="checkbox"/> Muscular Weakness <input type="checkbox"/> Paralysis	<input type="checkbox"/> Mental Status Change-Recent <input type="checkbox"/> Other: _____		
Sensory Deficit <input type="checkbox"/> No Known Problem	<input type="checkbox"/> Speech <input type="checkbox"/> Tactile <input type="checkbox"/> Pain	<input type="checkbox"/> Hearing <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Vision <input type="checkbox"/> Glasses	<input type="checkbox"/> Peripheral Neuropathy <input type="checkbox"/> Other: _____	
Integumentary <input type="checkbox"/> No Known Problem	<input type="checkbox"/> Intact <input type="checkbox"/> Decubiti <input type="checkbox"/> Scars	<input type="checkbox"/> Rash <input type="checkbox"/> Open Sores <input type="checkbox"/> Drainage	<input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Elastic Turgor <input type="checkbox"/> Non-Elastic Turgor	Color: <input type="checkbox"/> Pale <input type="checkbox"/> Dusky <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pink	<input type="checkbox"/> Other: _____
Musculoskeletal <input type="checkbox"/> No Known Problem	<input type="checkbox"/> Fracture <input type="checkbox"/> Dislocation <input type="checkbox"/> Stiffness	<input type="checkbox"/> Sprain <input type="checkbox"/> Pain <input type="checkbox"/> Amputation	<input type="checkbox"/> Contracture <input type="checkbox"/> Deformities <input type="checkbox"/> Weakness	<input type="checkbox"/> History of Recent Falls <input type="checkbox"/> Cane, Walker, Crutches, Prosthesis Used <input type="checkbox"/> Other: _____	
Respiratory <input type="checkbox"/> No Known Problem	<input type="checkbox"/> Short of Breath <input type="checkbox"/> Productive Cough <input type="checkbox"/> Non-Productive Cough <input type="checkbox"/> Hypoxia	Quality: <input type="checkbox"/> Easy <input type="checkbox"/> Labored <input type="checkbox"/> Shallow	Breath Sounds: <input type="checkbox"/> Clear: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Congested: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Wheeze: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Absent: <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Oxygen Use <input type="checkbox"/> Other: _____	
Cardiac <input type="checkbox"/> No Known Problem	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Rhythm <input type="checkbox"/> Palpitations <input type="checkbox"/> Edema	<input type="checkbox"/> Dizziness <input type="checkbox"/> Petechiae <input type="checkbox"/> High Blood Pressure	Peripheral Pulses: <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Absent	<input type="checkbox"/> Other: _____	
Endocrine <input type="checkbox"/> No Known Problem	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> Other: _____			
G.I. <input type="checkbox"/> No Known Problem	<input type="checkbox"/> Soft <input type="checkbox"/> Tender <input type="checkbox"/> Firm <input type="checkbox"/> Distended	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Dyspepsia <input type="checkbox"/> Dysphagia <input type="checkbox"/> Difficulty Chewing	Bowel Sounds: <input type="checkbox"/> Present <input type="checkbox"/> Absent	<input type="checkbox"/> Other: _____
G.U. <input type="checkbox"/> No Known Problem	<input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Dysuria	<input type="checkbox"/> Nocturia <input type="checkbox"/> Incontinence <input type="checkbox"/> Hematuria	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Other: _____	
Reproductive/Genital <input type="checkbox"/> No Known Problem	<input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Itching LMP: _____	<input type="checkbox"/> Discharge <input type="checkbox"/> Tenderness Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No Last PAP: _____	Breasts: <input type="checkbox"/> Lumps <input type="checkbox"/> Tenderness <input type="checkbox"/> Pain <input type="checkbox"/> Discharge	BSE*: <input type="checkbox"/> Yes <input type="checkbox"/> No Freq. _____ Last Mammogram: _____	
	<input type="checkbox"/> No Change <input type="checkbox"/> Lumps <input type="checkbox"/> Pain <input type="checkbox"/> Swelling	<input type="checkbox"/> Enlarged Prostrate <input type="checkbox"/> Itching <input type="checkbox"/> Discharge	TSE*: <input type="checkbox"/> Yes <input type="checkbox"/> No Freq.: _____		
Adult Immunizations: Pneumovac: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ "Flu" Shot: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____					
Current Medications: <input type="checkbox"/> Narcotics <input type="checkbox"/> Sedatives/Hypnotics <input type="checkbox"/> Muscle Relaxants					
Fall Risk Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Comments: _____					
Person Providing Above Information: _____					
RN/LPN Signature: _____			Date: _____	Time: _____	
BSE=Breast Self Examination		TSE=Testicular Self Examination		LMP=Last Menstrual Period	

Admission Data	Date _____	Admit by:	<input type="checkbox"/> Ambulatory	Vital Signs: T _____	
	Arrival Time _____		<input type="checkbox"/> Gurney	P _____	
	Room # _____		<input type="checkbox"/> Wheelchair	R _____	
	Height _____ in.		<input type="checkbox"/> Ambulance	BP(rt) _____	
	Weight _____ lbs _____ kg		<input type="checkbox"/> Other	BP(lft) _____	
	Reason for Admission (Patient's own words):				
	Related Symptoms and Onset:				
Medical History	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	
	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Asthma	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Heart Murmur	
	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> GI Bleeding or Ulcer	<input type="checkbox"/> Other _____	
	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Pacemaker		
	Previous Surgery:				
	Current Meds:				
	Allergies (drug or food):		<input type="checkbox"/> NKDA (no known drug allergy)	Intolerances/Side Effects (drug or food):	
	Med/Food: _____	Reaction: _____		Med/Food: _____	Reaction: _____
	Med/Food: _____	Reaction: _____		Med/Food: _____	Reaction: _____
	Med/Food: _____	Reaction: _____		Med/Food: _____	Reaction: _____
	Blood Transfusions: <input type="checkbox"/> No <input type="checkbox"/> Yes		Date: _____	Any Reaction: _____	
	Organ Donor: <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Diet: _____		Weight Loss _____		Weight Gain _____
	Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No		# Packs/Day _____	# of Years _____	
	Alcohol: <input type="checkbox"/> Yes <input type="checkbox"/> No		Type: _____	Frequency: _____	
Advance Directives: <input type="checkbox"/> Resuscitate <input type="checkbox"/> Do Not Resuscitate					
Specific Patient Data	Prone to Falls: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Date of Last Fall _____				
	Independent: <input type="checkbox"/> No <input type="checkbox"/> Yes Aids Used: _____				
	Present Living Arrangements: <input type="checkbox"/> Alone		<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Other Support	
	<input type="checkbox"/> With Others		<input type="checkbox"/> Personal Care Home		
Unit Orientation	Instructed in Use of: <input type="checkbox"/> Telephone		<input type="checkbox"/> Smoking Policy	<input type="checkbox"/> Nurse Call System	
	<input type="checkbox"/> Lights		<input type="checkbox"/> Visiting Hours	<input type="checkbox"/> Bed Controls	
Social/Emotional Discharge Planning	<input type="checkbox"/> Code Status	<input type="checkbox"/> Patient/Family Uncooperative	<input type="checkbox"/> Multiple Admissions	<input type="checkbox"/> Lives Out of Country	
	<input type="checkbox"/> Disoriented	<input type="checkbox"/> May Require Supervision	<input type="checkbox"/> Needs Home Assistance	<input type="checkbox"/> Insufficient Finances	
	<input type="checkbox"/> Terminal Illness	<input type="checkbox"/> May Require Placement	<input type="checkbox"/> Needs Adult Protection	<input type="checkbox"/> Elderly/Lives Alone	
	<input type="checkbox"/> Non-Compliant	<input type="checkbox"/> Possible Abuse/Neglect	<input type="checkbox"/> Alcohol/Substance Abuse	<input type="checkbox"/> Health Needs	
	Referred for Discharge Planning: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Social Service <input type="checkbox"/> Home Health				
	None Needed: <input type="checkbox"/>				

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NURSING DATA
6/90, R 7/98, 6/00, 1/02, 1/8/02, 9/02