Shasta Regional Medical Center

PATIENT:_____

New Patient Medical History

CHIEF COMPLAINT

What is the reason for your visit today? _____
Who is your primary care provider? _____
What pharmacy do you use? _____
Do you currently have a home health or hospice agency caring for you? y n
if yes what agency? _____

HPI

TELL US ABOUT YOUR WOUNDS:
Where is your wound located? _____
How long have you had the wound(s)? _____
How did the wound(s) occur or develop? _____
What have you been doing to treat your wound? _____
Are your wounds the result of an accident? Y N if yes, date of accident _____
Describe any signs or symptoms associated with your wound (odor, numbness, drainage, etc…):
_____

On scale of 1 – 10, with 10 being the worst, how do you rate your pain: _____
Describe your pain by checking the boxes, below, that apply.

☐ *Constant (never goes away)* ☐ *Intermittent (comes and goes)*

☐ *Aching* ☐ *Burning* ☐ *Throbbing* ☐ *Stabbing* ☐ *Shooting* ☐ *Sharp* ☐ *Dull* ☐ *Heavy*

☐ *Cramping* ☐ *Tender* ☐ *Easy to pinpoint* ☐ *Difficult to pinpoint*

Describe or list any conditions or activities that impact your wound, such as pain when walking or raising your leg:
_____

ADVANCED DIRECTIVES & INSTRUCTIONS: [CHECK ALL THAT APPLY]

☐ *I Have an Advance Directive*
☐ *Advance Directive Materials Were Provided to me*
☐ *I Have A Living Will*
☐ *I Have A Copy of My Living Will for the Hospital*
☐ *I Have A Durable Power of Attorney for Healthcare*
☐ *I Do Not Want to be Resuscitated*

ARE ANY OF THESE DOCUMENTS ON FILE WITH SRMC? Y N

Shasta Regional Medical Center

New Patient Medical History

PATIENT:_____

ALLERGIES [LIST ALL KNOWN ALLERGIES AND REACTIONS]

☐ No Known Allergies ☐ *Latex / Rubber* ☐ *Tape* ☐ *Iodine*
FOOD ALLERGIES:
MEDICATION ALLERGIES:
OTHER:

MEDICATIONS [LIST ALL MEDICINES YOU ARE CURRENTLY TAKING - INCLUDE OVER THE COUNTER, HERBAL & VITAMIN SUPPLEMENTS]

Write on Back if more room needed			
Medication	Amount	Dosage	How Often
EXAMPLE: *ASPIRIN*	*325MG*	*1 PILL*	*DAILY*

Shasta Regional Medical Center

New Patient Medical History

PATIENT:_____

REVIEW OF SYSTEMS [list all of your current complaints and symptoms]

CONSTITUTIONAL (GENERAL HEALTH)			EYES		
CURRENT COMPLAINTS & SYMPTOMS	*Yes*	*No*	CURRENT COMPLAINTS & SYMPTOMS	*Yes*	*No*
Chills			*Blurred Vision*		
Fatigue (tired all of the time)			*Dry eyes*		
Fever			*Glasses/Contacts*		
Loss of Appetite			*Vision Changes*		
Marked Weight Change			*Eye Pain*		
Night Sweats			*Other*		
Other					
EAR / NOSE / MOUTH / THROAT			RESPIRATORY		
Dental Problems			*Cough*		
Hearing Loss/Aid			*Hemoptysis (coughing blood)*		
Nasal Congestion			*Shortness of Breath*		
Painful or Swollen Lymph Nodes			*Wheezing*		
Sore Throat			*Oxygen in Use*		
Other			*Other*		
CARDIOVASCULAR (CENTRAL / PERIPHERAL)			GASTROINTESTINAL (GI)		
Chest Pain			*Acid Reflux*		
Diaphoresis (Sweating)			*Bowel Incontinence*		
Dyspnea on Exertion			*Change in Bowel Habits*		
Edema			*Constipation*		
Intermittent Claudication			*Diarrhea*		
Lower extremity (leg) resting pain			*Jaundice*		

Shasta Regional Medical Center

New Patient Medical History

PATIENT:_____

REVIEW OF SYSTEMS *CONTINUED* [list all of your current complaints and symptoms]

CONSTITUTIONAL (GENERAL HEALTH)		
CURRENT COMPLAINTS & SYMPTOMS	*Yes*	*No*
Orthopnea		
Palpitations		
Syncope (Fainting)		
Other		
GENITOURINARY (GU)		
Frequency		
Pregnant		
Urgency		
Urinary Incontinence		
Other		
NEUROLOGICAL		
Abnormal Gait		
Dizziness		
Headaches		
Loss of Protective Sensation		
Numbness		
Paralysis		
Seizures		
Syncope		
Tingling		
Tremors		
Weakness		
Other		
MUSCULOSKELETAL		
Decreased Activity		
Joint Pain		
Joint Swelling		
Assistive Devices		
Backache		
Contractures		
Deformities		
Muscle Pain		
Muscle Wasting		
Muscle Weakness		
Other		

GASTROINTESTINAL (GI)		
CURRENT COMPLAINTS & SYMPTOMS	*Yes*	*No*
Nausea/Vomiting/Diarrhea (N/V/D)		
Stomach/Abdominal pain		
Blood in Stool		
Other		
ENDOCRINE		
Cold Intolerance		
Heat Intolerance		
Polydypsia (Excessive Thirst)		
Polyuria (Excessive Urination)		
Other		
INTEGUMENTARY (HAIR/SKIN/NAILS)		
Change: Hair, Nails, Skin		
Dryness		
Calluses/Corns		
Change in Moles		
Hemosiderin Staining		
Hyperpigmentation		
Itching		
Lesions		
Rash		
Prone to Skin Tears		
Sun Sensitivity		
Other		
PSYCHIATRIC		
Anxiety		
Claustrophobia		
Depression		
Memory Loss		
Nervousness/Tension		
Suicidal		
Other		

Shasta Regional Medical Center

New Patient Medical History

PATIENT:_____

PAST MEDICAL HISTORY

CONSTITUTIONAL (GENERAL HEALTH)					
	Yes	*No*		*Yes*	*No*
			History of VRE or MRSA		
EAR / NOSE / MOUTH / THROAT					
Barotrauma (damage to ear drum)					
Sinusitis			*Tube Placement (in ear)*		
Tinnitus (ringing in ears)					
EYES					
Cataracts			*Cataract repair*		
Glaucoma			*Eyes surgery*		
Retinopathy (damage to the retina)			*Prosthetic eye*		
RESPIRATORY					
Abnormal Chest X-ray			*Pneumonia*		
Asthma			*Pneumothorax (collapsed lung)*		
Chest tube insertion			*Positive TB Test*		
Chronic Obstructive Pulmonary Disease (COPD)			*Pulmonary Embolus (blood clot in lung)*		
Emphysema			*Tuberculosis*		
Upper Respiratory Infection (URI)					
CARDIOVASCULAR (CENTRAL / PERIPHERAL)					
Congestive Heart Failure			*Murmur*		
Coronary Artery Disease (CAD)			*Myocardial Infarction (Heart attack)*		
Deep Vein Thrombosis (clot in the vein)			*Peripheral Vascular Disease*		
Hyperlipidemia (High cholesterol)			*Vasculitis*		
Hypertension (High blood pressure)					
Rheumatic Fever			*Venous insufficiency*		
GASTROINTESTINAL (GI)					
Cirrhosis of the Liver			*Special Diet*		
Crohn's Disease			*Colostomy*		
Gastro Esophageal Reflux (GERD)			*Ileostomy*		
Hepatitis (liver infection)			*Ulcerative Colitis*		

Shasta Regional Medical Center

New Patient Medical History

PATIENT:_____

PAST MEDICAL HISTORY *CONTINUED*

CONSTITUTIONAL (GENERAL HEALTH)					
	Yes	*No*		*Yes*	*No*
GENITOURINARY (GU)					
Benign Prostate Hyperplasia (enlarged prostate)			*Miscarriage*		
Dialysis			*Prostate Cancer*		
End Stage Renal Disease			*Sexually Transmitted Disease*		
Kidney Disease					
ENDOCRINE					
Gestational Diabetes (with pregnancy)			*Type 1 Diabetes (juvenile onset)*		
Thyroid Disease			*Type 2 Diabetes (adult onset)*		
MUSCULOSKELETAL					
Arthritis			*Osteoarthritis*		
Gout			*Osteomyelitis (bone infection)*		
Hip Fracture			*Other Fracture*		
Osteoporosis					
INTEGUMENTARY (HAIR / SKIN / NAILS)					
Burn			*Onchomycosis (nail fungal infection)*		
Malignancy (skin cancer)			*Scleroderma*		
NEUROLOGICAL					
Amyotrophic Lateral Sclerosis (ALS)			*Multiple Sclerosis*		
CNS Trauma Injury			*Stroke*		
Epilepsy			*Transient Ischemic Attack (TIA / mini-stroke)*		
Head Injury / LOC					
PSYCHIATRIC					
Alzheimer's			*Depression*		
Dementia (loss of mental skills)					
HEMATOLOGIC / LYMPHATIC					
Anemia (low blood count)			*Lymphedema*		
Anticoagulant Therapy			*Sickle Cell Anemia*		
ALLERGIC / IMMUNOLOGIC					
AIDS / HIV			*Reynaud's Disease*		
Lupus			*Rheumatoid Arthritis*		
Pyoderma Gangrenosum					

Shasta Regional Medical Center

New Patient Medical History

PATIENT:_____

PAST SURGICAL HISTORY (PLEASE PROVIDE PROCEDURES AND DATES AS BEST AS YOU CAN.)

FAMILY HISTORY

Condition:	Mother	Maternal GPs	Father	Paternal GPs	Sibling	Child	No History	NOTES
Cancer								
Diabetes Type I: _____ Type II: _____								
Heart Disease								
Hypertension								
Kidney Disease								
Lung Disease								
Mental Illness								
Seizures								
Stroke								
Thyroid Problems								
Tuberculosis								

Shasta Regional Medical Center

New Patient Medical History

PATIENT:_____

SOCIAL HISTORY

Smoking Status: ☐ *Current every Day* ☐ *Never* ☐ *Current some Day* ☐ *Former* ☐ *Current Status Unknown* ☐ *Unknown if ever smoked* ☐ *Heavy Tobacco Smoker* ☐ *Light Tobacco Smoker*
Smokeless Tobacco: ☐ *Never* ☐ *Rarely* ☐ *Moderate* ☐ *Daily*
Nicotine Gum: Y N *Electronic cigarettes: Y N*
Marital Status ☐ *Single* ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed* ☐ *Other:*
Occupation:
Retired (from):
Veteran: Y N
Children ☐ *No* ☐ *Yes* | *If Yes, how many:*
Caffeine Use: ☐ *Never* ☐ *Previously* ☐ *Currently* | *Type / Frequency:*
Alcohol Use: ☐ *Never* ☐ *Rarely* ☐ *Moderate* ☐ *Daily*
Illicit Drug Use: ☐ *Never* ☐ *Previously* ☐ *Currently* | *Type / Frequency:*
Cultural, Religious or Language Concerns that may affect your care:
Financial Concerns:
Do family and friends provide help when needed? ☐ *No* ☐ *Yes*
Support Systems Lacking: ☐ *No* ☐ *Yes*
Transportation Concerns (able to drive, etc.)?:
Able to Care for Self (dressing, bathing, etc.)? ☐ *No* ☐ *Yes* *If "No", explain:*
Do you reside in an Assisted Living: ☐ *No* ☐ *Yes* *Long Term Care Facility:* ☐ *No* ☐ *Yes* *SNF:* ☐ *No* ☐ *Yes*
Who do you live with?
Do you need assistance with transfers or repositioning? Y N, If yes, explain:
Do you feel safe at home? Y N
Any concerns about Abuse or Neglect: ☐ *No* ☐ *Yes* *CONCERNS:*
Do you have any feelings of wanting to harm yourself or others? ☐ *No* ☐ *Yes* *CONCERNS:*

Patient Signature: _____ **DATE:** _____ **TIME:** _____
(Or Legal Guardian/POA)

I have reviewed the New Patient Medical History with the patient / caregiver as part of the Initial Nursing Assessment.

Nurse Signature: _____ **DATE:** _____ **TIME:** _____