

**GREENWOOD HOUSE
ADMISSION HISTORY PHYSICAL FORM**

Resident Name: _____

Date: _____ Reason for Admission: _____

History of Present Illness(es)

Past Medical History:

Surgical Procedures:

Medications:

Allergies and Sensitivities:

Family History: ("non-contributory" not acceptable):

Social History

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Review of systems: Check if negative. Highlight or circle issues - pull contributory labs, x-rays, etc.	
	<input type="checkbox"/> Appetite is normal <input type="checkbox"/> Denies weight gain or loss <input type="checkbox"/> Denies fever or chills.
Skin	Denies <input type="checkbox"/> new lesions <input type="checkbox"/> changes in hair or nails <input type="checkbox"/> rash
Heme	Denies <input type="checkbox"/> easy bruisability <input type="checkbox"/> gland enlargement <input type="checkbox"/> abnormal bleeding
Head	Denies <input type="checkbox"/> headache <input type="checkbox"/> recent trauma
Eyes	Denies <input type="checkbox"/> double vision <input type="checkbox"/> blind spots <input type="checkbox"/> cataracts <input type="checkbox"/> glaucoma <input type="checkbox"/> macular degeneration Last saw eye doctor _____
Mouth	Last saw dentist _____. Denies <input type="checkbox"/> bleeding <input type="checkbox"/> lesions. Dentures? Y/N
Pharynx/Larynx	Denies <input type="checkbox"/> sore throat <input type="checkbox"/> hoarseness <input type="checkbox"/> voice change <input type="checkbox"/> difficulty swallowing
Breasts	Denies <input type="checkbox"/> new bumps <input type="checkbox"/> lumps <input type="checkbox"/> discharge <input type="checkbox"/> deferred. Examine own breasts monthly? Y/N
Respiratory	Denies <input type="checkbox"/> cough <input type="checkbox"/> sputum production <input type="checkbox"/> hemoptysis <input type="checkbox"/> chest pain <input type="checkbox"/> TB exposure <input type="checkbox"/> pleurisy <input type="checkbox"/> night sweats
Cardiac	Denies <input type="checkbox"/> chest pain <input type="checkbox"/> shortness of breath <input type="checkbox"/> palpitations <input type="checkbox"/> ankle swelling <input type="checkbox"/> fainting <input type="checkbox"/> heart murmur <input type="checkbox"/> valvular Heart disease <input type="checkbox"/> history of angina/infarction <input type="checkbox"/> circulatory problems
Gastrointestinal	Denies <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> history of hepatitis or yellow jaundice <input type="checkbox"/> heartburn <input type="checkbox"/> ulcers <input type="checkbox"/> blood in stool <input type="checkbox"/> throwing in blood. Denies <input type="checkbox"/> recent change in bowel habits <input type="checkbox"/> stool color <input type="checkbox"/> rectal pain. Denies History of <input type="checkbox"/> hemorrhoids <input type="checkbox"/> hernia.
Urinary	Denies <input type="checkbox"/> incontinence <input type="checkbox"/> burning <input type="checkbox"/> frequency <input type="checkbox"/> urgency <input type="checkbox"/> polyuria <input type="checkbox"/> nocturia <input type="checkbox"/> oliguria <input type="checkbox"/> retention <input type="checkbox"/> dribbling <input type="checkbox"/> hesitancy <input type="checkbox"/> poor stream. Denies <input type="checkbox"/> blood in urine <input type="checkbox"/> history of UTI <input type="checkbox"/> stones.
Genital	Denies history of <input type="checkbox"/> venereal disease. Men: Denies <input type="checkbox"/> genital lesions <input type="checkbox"/> pain <input type="checkbox"/> discharge <input type="checkbox"/> testicular pain. Women: Denies <input type="checkbox"/> vaginal discharge <input type="checkbox"/> bleeding. <input type="checkbox"/> deferred
Endocrine	Denies <input type="checkbox"/> fatigue <input type="checkbox"/> goiter <input type="checkbox"/> temperature intolerance <input type="checkbox"/> change in features <input type="checkbox"/> thyroid history
Musculoskeletal	Denies <input type="checkbox"/> pain in muscles <input type="checkbox"/> joints <input type="checkbox"/> arthritis
Neuro	Denies <input type="checkbox"/> numbness <input type="checkbox"/> tingling <input type="checkbox"/> weakness <input type="checkbox"/> tremor <input type="checkbox"/> forgetfulness <input type="checkbox"/> history of stroke.
Misc	Denies <input type="checkbox"/> recent falls in last six months. Denies <input type="checkbox"/> difficulty walking. Denies <input type="checkbox"/> difficulty sleeping. Denies <input type="checkbox"/> Depressive symptoms <input type="checkbox"/> tearfulness <input type="checkbox"/> hopelessness <input type="checkbox"/> suicidal/homicidal ideation

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Physical Exam: Check if negative:

General	
Vital Signs	BP _____ P _____ T _____ RR _____ Weight _____
	Pain _____
Head	<input type="checkbox"/> normocephalic <input type="checkbox"/> atraumatic
Hair	<input type="checkbox"/> normal texture
Skin	
Eyes	Pupils <input type="checkbox"/> equal <input type="checkbox"/> round <input type="checkbox"/> reactive to light and accommodation; <input type="checkbox"/> extra ocular movement intact.
Ears	<input type="checkbox"/> tympanic membranes intact <input type="checkbox"/> canals clear
Nose and Throat	<input type="checkbox"/> unremarkable Oral mucosa: _____ Dentition: _____
Neck	Supple without <input type="checkbox"/> jugular venous distention <input type="checkbox"/> adenopathy <input type="checkbox"/> thyromegaly
Back	<input type="checkbox"/> normal with kyphoscoliosis
Breasts	Without <input type="checkbox"/> mass <input type="checkbox"/> tenderness <input type="checkbox"/> discharge
Lymphatics	Without <input type="checkbox"/> cervical <input type="checkbox"/> inguinal <input type="checkbox"/> axillary adenopathy
Lungs	<input type="checkbox"/> clear to percussion and auscultation; <input type="checkbox"/> air entry normal
Cardiac	Regular <input type="checkbox"/> rhythm and rate; without <input type="checkbox"/> murmurs <input type="checkbox"/> rubs <input type="checkbox"/> gallops.
Abdomen	<input type="checkbox"/> soft <input type="checkbox"/> bowel sounds present; without <input type="checkbox"/> mass <input type="checkbox"/> tenderness <input type="checkbox"/> organomegaly.
Genital	Men: Women: <input type="checkbox"/> External vulvae nl, <input type="checkbox"/> vaginal mucosa nl, <input type="checkbox"/> deferred
Rectal	<input type="checkbox"/> normal sphincter tone <input type="checkbox"/> normal stool color; without <input type="checkbox"/> mass <input type="checkbox"/> tenderness
Prostate	Prostate size: <input type="checkbox"/> Smooth <input type="checkbox"/> firm <input type="checkbox"/> non-nodular <input type="checkbox"/> non-tender <input type="checkbox"/> deferred
Extremities	Without <input type="checkbox"/> clubbing <input type="checkbox"/> cyanosis <input type="checkbox"/> edema; <input type="checkbox"/> peripheral pulses intact.
Neurologic	<input type="checkbox"/> awake <input type="checkbox"/> alert <input type="checkbox"/> Cranial nerves II-XII grossly intact <input type="checkbox"/> sensorimotor intact <input type="checkbox"/> without focal signs
Mental State	St Louis Exam Mini-mental state exam score (if applicable).

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Prognosis/Condition/Rehabilitation Potential: _____

Preventative Health

Vaccines: Pneumovax Date _____
 Flu Date _____
 D/T Tetanus Date _____
 Zostivax Date _____
 Other: _____

Advanced Directives:

Health Care Proxy/Living Will? Yes No _____
DNR: Yes No DNH Yes No
 Other care request _____

Functional Status:

Ambulation: independent assisted
 no assistive device cane walker wheelchair bedbound
Transfers: independent assisted
Dressing: independent supervised assisted
Feedings: independent assisted dependent enteral
Toileting: independent assisted
Continenence (Bladder): continent Continenence (Bowel): continent
 incontinent incontinent

Labs (include dates): _____

Assessment/Plan: _____

(if additional space is needed, use progress note)

M.D. Signature: _____

Date: _____