D2-1

PHS INTAKE RECEIVING AND SCREENING VOLUSIA

LAST NAME	FIRST NAME	MI
Wooley	Heidi	M

STATE ID	VISIT ID	ALIAS	DOB
844775			9/21/73

DATE: MAR 26, 2011 | TIME: 22:44 ☐ AM ☑ PM | SEX: ☐ MALE ☑ FEMALE | SOCIAL SECURITY NUMBER: [redacted]

Intake Refused? ☐ Yes ☑ No

Most Recent Incarceration: ☑ None When? _____ Where? _____

Have you ever been incarcerated here? ☑ Yes ☐ No If yes, when? _____

Inmate Transfer? ☐ Yes ☑ No If yes, records received? ☐ Yes ☐ No

☐ Interpreter Used Name: 816524/80/047

Primary Care Provider: ☑ None Name: _____

Private Insurance: ☑ None Name: _____

CRITICAL OBSERVATION

Urgent/Emergent Medical Referral
☐ Yes ☑ No Indication
☐ Severe Injury ☐ Life Threatening Illness ☐ Uncontrolled Bleeding
☐ Severe Pain ☐ Head Trauma w/Mental Status Change
☐ Other _____

Responsiveness: ☑ Alert ☐ Verbal Stimulus ☐ Painful Stimulus ☐ Unresponsive
Describe Responsiveness _____
Oriented To: Person ☑ Yes ☐ No; Place ☑ Yes ☐ No; Time ☑ Yes ☐ No
Describe _____

Urgent/Emergent Security Referral
☐ Yes ☑ No
☐ Uncooperative ☐ Threatening
☐ Other _____

Urgent/Emergent Mental Health Referral
☐ Yes ☑ No
Reason _____
☐ Active Hallucinations ☐ Active Delusions
☐ Actively Suicidal
☐ Other _____

Communicable Diseases: Possible

MRSA	☐ Yes	☑ No
Varicella (Chicken Pox)	☐ Yes	☑ No
Herpes Zoster (Shingles)	☐ Yes	☑ No
Lice/Pediculosis	☐ Yes	☑ No
Jaundice	☐ Yes	☑ No
Needlemarks	☐ Yes	☑ No

Other _____

Mobility Restrictions
☐ Yes ☐ Deformity ☐ Cast ☐ Paraplegic
☑ No ☐ Amputation ☐ Splint ☐ Quadriplegic
☐ Other _____

Physical Aids
☐ Yes ☐ Wheelchair ☐ CPAP
☑ No ☐ Crutches/Canes
☐ Other _____

Deaf
☐ Yes ☑ No
☐ Right ☐ Left ☐ Both
☐ Other _____

Blind
☐ Yes ☑ No
☐ Right ☐ Left ☐ Both
☐ Other _____

VITAL SIGNS ☐ One or more vital signs refused

Height	Weight	Temperature	Blood Pressure (Recheck If Indicated)	Pulse ☐ A ☐ P	Respirations	Pulse Ox	Finger Stick	Peak Flow
5'2" ☐ Act ☐ Rptd	212 lbs ☑ Act ☐ Rptd	98.3	166/96 Initial	90 Initial	16 Initial	98 Initial	N/A Initial	N/A Initial
			_____ Recheck *	_____ Recheck *	_____ Recheck *	_____ Recheck *	_____ Recheck *	_____ Recheck *

HISTORY

Recent Major Surgical History (within 90 days)
☐ Yes ☑ No
☐ Brain Surgery ☐ Heart Surgery
☐ Abdominal Surgery ☐ Other _____

Recent Medical Hospitalizations (within 90 days)
☐ Yes ☑ No
If yes, describe _____

Ever had a transplant? ☐ Yes ☑ No
☐ Kidney ☐ Other _____
Current medication for organ transplant? ☐ Yes ☑ No

Female History
Date of Last Menstrual Period? ☐ N/A 4
Are you currently pregnant? ☐ Y ☑ N ☐ Maybe / Don't Know
Pregnancy Test Result ☐ Pos ☐ Neg ☐ Scheduled ☐ N/A
Fingerstick Result (If pregnancy test Positive) _____
Have you delivered, had a miscarriage, or abortion in the past 12 weeks? ☐ Y ☑ N

Pregnancies	
Full Term	3
Last Pregnancy?	12/10
Premature	0
Abortions	5
Last abortion?	2010
Living	3

Pap Smear ☐ Unknown ☐ None
Date of last 2011
Result ☑ Normal ☐ Abnormal ☐ Don't Know

Mammogram ☐ Unknown ☑ None
Date of last _____
Result ☐ Normal ☐ Abnormal ☐ Don't Know

PRE-ADMISSION MEDICATIONS ☐ None ☐ Unknown ☐ See Attached Form

NAME	DOSE	SIG	ROUTE	LAST DOSE	REASON	VERIFIED
Labetalol	?			today	BP	☐
						☐
						☐
						☐

ALLERGIES – Do you have any allergies (food, medication, environmental)? ☑ Yes ☐ No ☐ See Attached Form

ALLERGY	REACTION TYPE (Hives, Rash, SOB, Anaphylaxis, Shock)	ALLERGY	REACTION TYPE (Hives, Rash, SOB, Anaphylaxis, Shock)
Sulfa	Hives/Bloody nose		

ALCOHOL USE

Do you drink alcohol? ☑ Yes ☐ No
What? _____
Last Use? _____
How much? _____
How often? _____
Excessive Drinker? ☐ Yes (CIWA) ☐ No
Ever had alcohol withdrawals, tremors, seizures, or DT's associated with stopping alcohol? ☐ Yes (CIWA) ☐ No
If yes, when? _____

TOBACCO USE

Do you smoke?
☑ Current ☐ Former ☐ Never
Amount? 1/2 packs/day
How long? _____

SUBSTANCE/DRUG USE

Do you use drugs? ☑ Yes ☐ No
Do you use injectable drugs? ☐ Yes ☑ No Last use of injectable drugs? _____

	How often?	How much?	Last use?	
☐ Heroin	_____	_____	_____	☐ Hx of withdrawal
☑ Narcotics	occ.	1pill	yesterday	☐ Hx of withdrawal
☐ Benzodiazepines	_____	_____	_____	☐ Hx of withdrawal
☐ Methamphetamines				
☐ Cocaine				
☐ Other _____				

COMMUNICABLE DISEASES

Hepatitis

Have you ever had hepatitis? ☐ Yes ☑ No
Hep A? ☐ Yes ☑ No
Hep B? ☐ Yes ☑ No ☐ Hx of treatment
Hep C? ☐ Yes ☑ No ☐ Hx of treatment

STD's

Do you currently have an STD? ☐ Yes ☑ No
☐ Syphilis? ☐ Being Treated
☐ Gonorrhea? ☐ Being Treated
☐ Chlamydia? ☐ Being Treated
☐ Herpes? ☐ Being Treated
☐ Other? _____ ☐ Being Treated
Do you currently have symptoms? ☐ Yes ☐ No
Describe _____

HIV/AIDS

Do you have HIV infection or AIDS? ☐ Yes ☑ No
Are you currently taking medication(s)? ☐ Yes ☐ No
When diagnosed? _____
History of opportunistic infections?
☐ None ☐ Thrush ☐ PCP
☐ Zoster ☐ Cryptococcal Meningitis ☐ Toxo
Have you been treated? ☐ Yes ☐ No
Are you currently receiving OI medication(s)? ☐ Yes ☐ No

TB Symptoms

Do you have?
Weight loss ☐ Yes ☑ No
Night Sweats ☐ Yes ☑ No
Fever ☐ Yes ☑ No
Persistent Cough > 2 weeks ☐ Yes ☑ No
Coughing Blood ☐ Yes ☑ No
Weak/Tired ☐ Yes ☑ No

TB Skin Test

Prior + PPD? ☐ Yes ☑ No ☐ Don't Know
Current TB medication? ☐ Yes ☐ No
Current LTBI medication? ☐ Yes ☐ No
Plant PPD Now? ☐ Yes ☐ No
If no, Reason _____
Location? ☐ LFA ☐ RFA
Date Planted _____ Planter's Initials _____

CHRONIC ILLNESSES

Asthma

Do you have asthma? ☐ Yes ☑ No
How long? _____
Last episode of shortness of breath? _____
ER visit in last 90 days? ☐ Yes ☐ No
If yes, when? _____
Hospitalization in last year? ☐ Yes ☐ No
If yes, when? _____
Ever intubated? ☐ Yes ☐ No
If yes, when? _____
Currently on steroids? ☐ Yes ☐ No
Peak Flow ( )

Cardiovascular Disease (ask each question)

Have you ever had any of the following problems with your heart:

Angina?	☐ Yes ☑ No	Atrial Fibrillation?	☐ Yes ☑ No
Stents?	☐ Yes ☑ No	Pacemaker?	☐ Yes ☑ No
Heart Attack?	☐ Yes ☑ No	Internal Defibrillator?	☐ Yes ☑ No
Bypass Surgery?	☐ Yes ☑ No	Endocarditis?	☐ Yes ☑ No
CHF?	☐ Yes ☑ No	Blood clot in lungs or legs?	☐ Yes ☑ No
Heart valve replacement?	☐ Yes ☑ No	Are you taking Warfarin, Coumadin, or Jantoven?	☐ Yes ☑ No

Date of onset: _____ Last episode: _____
Comments

Cerebrovascular Disease

Have you ever had a:
CVA (Stroke)? ☐ Yes ☑ No
When was last? _____
Within past year? ☐ Yes ☐ No
TIA (Mini-Stroke)? ☐ Yes ☐ No
When was last? _____
Within past year? ☐ Yes ☐ No
Comments _____

Diabetes

Have you ever had diabetes or a problem with high blood sugar? ☐ Yes ☑ No
How long? _____
Are you currently taking medication(s)? ☐ Yes ☐ No
Are you currently taking insulin? ☐ Yes ☐ No
Hospitalization in last year? ☐ Yes ☐ No
If yes, when? _____
Finger Stick ( )
If Finger Stick > 300, ask the following
Nausea? ☐ Yes ☐ No
Vomiting? ☐ Yes ☐ No
Excessive thirst? ☐ Yes ☐ No
Urine Ketones (If indicated) ( )

Hypertension

Have you ever had high blood pressure or hypertension? ☑ Yes ☐ No
How long? 27
Are you currently taking medication(s)? ☑ Yes ☐ No

Epilepsy/Seizure

Have you ever had a seizure or convulsion? ☐ Yes ☑ No
Last Seizure? _____
Frequency greater than once a month? ☐ Yes ☐ No
Two or more anticonvulsants? ☐ Yes ☐ No

Gastrointestinal

Have you ever been treated for problems with stomach or bowels? ☐ Yes ☑ No
Have you ever vomited blood? ☐ Yes ☑ No Frequency? _____ Last? _____ Comments _____
Ever had dark, black stools from bleeding? ☐ Yes ☑ No Frequency? _____ Last? _____ Comments _____
Have you ever been told you have cirrhosis? ☐ Yes ☑ No Comments _____

Cancer

Have you ever had cancer? ☐ Yes ☑ No
Do you currently have cancer? ☐ Yes ☑ No ☐ Unknown
Are you currently being treated for cancer? ☐ Yes ☑ No

Dialysis

Are you currently on dialysis? ☐ Yes ☑ No
Are you receiving your dialysis treatments? ☐ Yes ☑ No
Type? ☐ Hemodialysis ☐ Peritoneal
Number of times per week? _____
Last dialyzed? _____

COPD/Emphysema

Do you have COPD or emphysema? ☐ Yes ☑ No
O2 dependent? ☐ Yes ☑ No
Peak Flow ( )

Other Current Significant Medical Conditions: Allergies

Referral Needed? ☐ Yes ☑ No

MENTAL HEALTH

Do you have a history of a mental health disorder?	☐ Yes	☑ No	Have you been diagnosed with schizophrenia?	☐ Yes	☑ No
Have you been diagnosed as bipolar?	☐ Yes	☑ No	Have you been diagnosed with major depression?	☐ Yes	☑ No
Do you feel hopeless or helpless?	☐ Yes	☑ No	History of psychotropic medication(s)?	☐ Yes	☑ No
History of psych hospitalization?	☐ Yes	☑ No			
Within last year?	☐ Yes	☑ No			
History of hearing things?	☐ Yes	☑ No	History of seeing things?	☐ Yes	☑ No
Are you thinking about hurting yourself?	☐ Yes	☑ No			
Family/friends history of suicide?	☐ Yes	☑ No	Recent significant loss?	☐ Yes	☑ No
History of suicide attempt(s)?	☑ Yes	☐ No	Last attempt? 9/16		
Are you thinking about suicide now?	☐ Yes	☑ No			
Are you thinking about hurting others?	☐ Yes	☑ No	Ever hospitalized from head trauma?	☐ Yes	☑ No
History of: Special education placement?	☐ Yes	☑ No	Learning disability?	☐ Yes	☑ No
Developmental disability?	☐ Yes	☑ No	Mental retardation?	☐ Yes	☑ No
History of violent behavior?	☐ Yes	☑ No	History of victimization?	☐ Yes	☑ No
History of sex offenses?	☐ Yes	☑ No			

EXAMINATION

General Appearance ☐ NAD ☑ Appears Hydrated ☐ Other _____

Oral Screening — Describe

☑ Unremarkable ☐ Missing Teeth ☐ Swelling
☐ Abscesses ☐ Cavities ☐ Thrush
☐ Lesions ☐ Dentures Loose ☐ Other

Skin — Describe

Visible skin exam? ☑ Yes ☐ No
☑ Unremarkable ☐ Surgical Scars ☐ Jaundice
☐ Open Lesion(s) ☐ Rash ☐ Pallor
☐ Sores ☐ Tracks ☐ Other
☐ Lacerations ☐ Tattoos

DISPOSITION

Placement
☑ GP ☐ Isolation: Reason _____
☐ Infirmary ☐ Observation
☐ Suicide Watch ☐ Other _____

Referral
☑ H & P ☑ Routine ☐ Expedited
☐ Nursing Sick Call ☐ Routine ☐ Expedited
☐ MD/NP/PA Sick Call ☐ Routine ☐ Expedited
☐ Mental Health Referral ☐ Routine ☐ Expedited
☑ Chronic Care Clinic ☑ Routine ☐ Expedited
☐ Dental Referral ☐ Routine ☐ Expedited

Notification
☐ Immediate Supervisor
☐ MD/NP/PA On Call
☐ ER For Transport

Consent for Treatment Signed
☑ Yes ☐ No Reason _____

Access to Care Reviewed
☑ Yes ☐ No Reason _____

Grievance Process Explained
☑ Yes ☐ No Reason _____

ADDITIONAL COMMENTS

My information is correct and I accept the provision of medical, dental, and mental health care.

Patient's Signature	Interviewer's Name (Print) D. ZIHAL, EMT-P	Interviewer's Signature	Date MAR 26 2011
Secondary Review (If indicated)	H. HEIKKINEN, RN	H. Heikkinen RN	3/27/11
	Name (Print)	Signature	Date