**McLAREN FLINT**
**Flint, Michigan**

**NURSING ADMISSION HISTORY FORM - Downtime**

**Admission Data**
Unit Admission Date/Time________________ Admitted From________________
Informant ________________Oriented/Unit ☐ Not Oriented ________________
Primary Contact ________________Relationship ________________ Phone ________________
Advance Directive________________ End/Life Desires ________________ Code Status ________________

**Drug Allergies**
No Known Allergies ☐ Drugs/Reactions ________________

**Other Allergies**
No Known Allergies ☐ Allergens/Reactions________________

**Medical History**
Current Symptoms/Length________________
Previous Illness/Hospitalization ________________
Previous Surgery________________
Treatment/Reaction ________________
Dialysis/CAPD ________________
Communicable Diseases ________________ Pneumococcal Vaccine ☐
Immunizations________________ Last Tetanus Immunization ________________
TB/Risk Assessment ________________
Family Disease History ________________
________________ Admission Braden Scale ________________

**Diabetes**
No History Diabetes ☐ Type________________ Home Blood Test ________________
Home Urine Test________________ Who Tests ________________
Hypoglycemic Reaction________________
Home Insulin ________________

**Medications**
Prescription Meds ________________
Over the Counter Meds ________________
Herbal/Natural Meds ________________
Aerosol/Inhaler Meds________________
Birth Control Meds________________
Disposition/Meds________________ Takes Meds________________

**Verbal/Sensory**
Language Spoken________________ Dominant Hand ________________
Communication Barrier________________ Neurodeficit ________________
Learns Best By________________ Denies Problem ☐

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**NURSING ADMISSION HISTORY FORM DOWNTIME**

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## Nutrition
Last Oral Intake: Solids________________ Fluids________________
Appetite____________ Meals Per Day________ Diet Type________________
Food Intolerance________________ TPN/PPN________________
Oral Supplement/Tube Feeding ________________
Eating Problems________________ Weight History________________Denies Problem ☐

## Elimination
Pediatric Toilet Training - Completed ☐ In Progress ☐ Child's BM Name ________ Child's Urine Name________
Bowel: Number Stools________ Last BM________ Bowel Problems________Bowel Assist________
Bladder: Last Voided________________ Bladder Problems ________________
Bladder Assist________________ Cath Insert________Self-cath Times ________

## Psychosocial
Family Structure____________ Lives In________________ Lives With ________
Employment________________ Community Services________________
Home Care________________ Medical Equipment Vendor________________
Hospice________________ Family Assist Required ________________
Discharge Assist________________ Spiritual/Cultural ________________
Lifestyle Change________________ Coping Behavior ________________
Abuse________________ Tobacco Use ________________
Alcohol Use ________________ Substance Use ________________

## Reproductive
Sexually Active ☐ Multiple Partners ☐ Menstruation/Last Menstrual Period ________________
Amenorrhea ☐ Menopause ☐ Problems________________Gravida ________ Para ________
Possibly Pregnant ☐ Pregnant/Weeks________ Last PAP________ Last Mammogram________
Last Prostate Exam________________ Self Exam - breasts ☐ testicles ☐ Denies Problems ☐

## Assistive Devices
Invasive Line/Type/Date Inserted________________________ EMS IV Start ☐
Opthalmic/Audio/Speech Aids/Oral Devices ________________ Disposition ________________
Activity Device________________ Prosthesis________________ Splint ________
Pacemaker ________________ Cast ________________ Brace ________
Home Equipment________________________ Infusion Pump________________
Respiratory Equipment________________Oxygen________ lpm SVN Treatment ________________
Trach Oxygen________________

## Activities of Daily Living
Activity/Assistance________________________________
Mobility ________________ Walk w/Assist____ persons Wheelchair w/Assist ____ persons
Transfer w/Assist_____ persons Stairs w/Assist____ persons Tub ☐ Shower ☐
Home Entry Steps_____ Levels/Home_____ Level/Bedroom_____ Level/Bathroom_____
Barriers__________ Discharge Transportation _____ Eating/Feeding__________
Medication/Administration________________ Sleep Pattern__________
Sleeps______ hrs Pillow/Used________ Sleeps in Chair ☐

## Interventions
Notified________________ ________________
Wrist Bands On: Identification ☐ Allergy ☐ LRH Latex Allergy ☐ DNR/No Code ☐ L No BP/No Lab ☐ R No BP/No Lab ☐
Referral To ________________________________
Patient Belongings/Disposition ________________________ Cash Amount ________
Discharge Ed Needs ________________________________

Signature________________________ RN Date________________ Time________________

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