

VASCULAR ACCESS

N/A

VASCULAR ACCESS #1	Site / Type:	Insertion Date:	Condition:
IV Solution:		Rate:	
VASCULAR ACCESS #2	Site / Type:	Insertion Date:	Condition:
IV Solution:		Rate:	

Other:

MEDICAL HISTORY

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> HIV	<input type="checkbox"/> Rheumatic Disease	<input type="checkbox"/> Urinary/Genital/Kidney Problems
<input type="checkbox"/> Back / Neck Problem	<input type="checkbox"/> Glaucoma/Cataracts	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Recent exposure to communicable disease (i.e. Chicken Pox)
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> GYN Problems	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stroke	Comments:
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid Disease	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pregnant or Possible	<input type="checkbox"/> Other (Describe)	_____
<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Recent Falls	_____	_____

CHIEF COMPLAINT:

MEDICAL HISTORY:

SURGICAL HISTORY:

	Yes	No	
ETOH Consumption?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, How many drinks per day? _____
Drug Use?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, Describe type, frequency, usage? _____
Caffeine Intake?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, Amount per day? _____
Tobacco Use?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, packs per day? _____

List All Medications Prior to Recent Hospitalization: (Including Prescription and OTC: Medications, Vitamins and Herbs)

Are there any religious / spiritual issues that will effect your care? Yes No Explain:

Are there any cultural issues that will effect your care? Yes No Explain:

NEUROLOGIC

LOC: Awake, Alert, and Oriented to:	Person	Place	Time	Situation	Normal	Impaired			
Other, Describe:	_____				Hearing	<input type="checkbox"/>	<input type="checkbox"/>		
Affect: Appropriate	Calm	Flat	Agitated	Anxious	Depressed	Cooperative	Uncooperative		
PERRLA: Yes	No	Describe:	_____				Vision	<input type="checkbox"/>	<input type="checkbox"/>
Drift Test: Equal Bilaterally	Impaired:	R	L	Leg Lift to 30°:	Equal Bilaterally	Impaired:	R	L	
ROM Intact: Yes	No	Describe:	_____				Speech	<input type="checkbox"/>	<input type="checkbox"/>
Sensation Equal to All Extremities: Yes	No	Describe:	_____				Describe:	_____	

Comments:

RN Signature _____

Date _____

NURSING

TRANSDISCIPLINARY ASSESSMENT

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