GLEN OAKS HOSPITAL

Patient Identification

MEDICAL SCREENING FORM

Patient Name: _____ Patient Date of Birth: _____

Influenza Screening

1. Have you recently had any flu like symptoms or been treated for flu? (fever, cough, body aches, vomiting, diarrhea) _____
2. Have you recently been exposed to anyone who has exhibited any of the above symptoms? _____

This brief questionnaire is a screening tool to help during the initial assessment process.

Do you currently have or have you ever had:		OR	Have you been vaccinated for:
Measles	□ NO □ Yes	Date: _____	□ NO □ Yes
Mumps	□ NO □ Yes	Date: _____	□ NO □ Yes
Rubella	□ NO □ Yes	Date: _____	□ NO □ Yes
Influenza	□ NO □ Yes	Date: _____	□ NO □ Yes
Chicken Pox	□ NO □ Yes	Date: _____	□ NO □ Yes
Hepatitis A	□ NO □ Yes	Date: _____	□ NO □ Yes
Hepatitis B	□ NO □ Yes	Date: _____	□ NO □ Yes
Hepatitis C	□ NO □ Yes	Date: _____	□ NO □ Yes
HIV	□ NO □ Yes	Date: _____	
Tuberculosis	□ NO □ Yes	Date: _____	
Other:	□ NO □ Yes	Date: _____	□ NO □ Yes Date: _____
MRSA	□ NO □ Yes	Date: _____	

2. Are you now under the care of a physician or taking any medication for a communicable disease?
□ NO □ Yes (Please note any current treatment for any areas checked): _____

3. Have you had recent contact with someone with any of the above illnesses? □ NO □ Yes
If yes which one (s) and when: _____

4. Have you ever been tested for Tuberculosis? □ NO □ Yes If yes, when? (Date) _____

5. Have you ever tested positive for TB? □ NO □ Yes
If yes, did you have a chest x-ray? □ NO □ Yes
Were you treated? □ NO □ Yes If yes, when? (Date):_____
What kind of treatment: _____

6. Please check yes or no to ALL symptoms as they apply to you – ***please mark current symptoms only***:

Productive cough (3 wks or more)	□ NO □ Yes	Persistent Weight Loss without Dieting	□ NO □ Yes
Persistent Low Grade Fever	□ NO □ Yes	Night Sweats	□ NO □ Yes
Loss of Appetite	□ NO □ Yes	Swollen Glands, usually in the Neck	□ NO □ Yes
Recurrent Kidney Infections	□ NO □ Yes	Shortness of Breath **(current)**	□ NO □ Yes
Chest Pain **(current)**	□ NO □ Yes	Any recent falls?	□ NO □ Yes

7. Are you currently pregnant? □ NO □ Yes Date of Last Menstrual Cycle: _____

8. **Other *current* medical conditions:** **ALLERGIES (includes medications, foods, etc)**_____

Medical Status	Yes	No	Medical Status	Yes	No
Seasonal Allergies			Hypertension		
Asthma			Incontinence		
Diabetes			Open Wound		
Heart Disease			Sutures		
CVA (Stroke)			Active Bleeding		
Hearing/Vision Impaired			GI Dysfunction		
Sleep Apnea (different from insomnia)			Special Equipment (explain)		
Abdominal Pain (current)			Current Broken Bones/Fracture		
Muscle Pain (current)			Seizures		
Head Injury (recent)			Other (explain)		

9. Please list any problems with mobility/movement or areas where you might need assistance while at Glen Oaks Hospital:

_____

10. List any medical concerns, not previously addressed, that you feel our staff need to be aware of; for example a wound or skin condition?

_____

_____

11. Do you require any special medical equipment for your care? _____

12. In the previous 21 days, has the individual resided or traveled to any of the following countries in West Africa: Liberia, Sierra Leone, Guinea, or any region where Ebola Virus Disease (EVD) transmission is active? ☐ Yes ☐ No

If yes, location: _____Dates of travel:_____

13. In the previous 21 days, has the individual had contact with a patient known or suspected to have Ebola Virus Disease? ☐ Yes ☐ No

FOR STAFF USE ONLY

After review of medical-screen answers, what actions were taken by **TRIAGE** counselor: _____

Reviewed By Nursing (if applicable): _____ Date/Time: _____

Vital Signs: BP: _____ Pulse: _____ Respirations: _____ Temp: _____ O2 Sat.:_____ Breathalyzer: _____

Weight: _____ Height: _____ If Diabetic – must get blood sugar: _____ In Current Withdrawals? Initiate CIWA/COWS

Date/Time: _____ **Triage Staff**: _____ **Admission Assessor**: _____

DOCUMENT ATTEMPT TO CONTACT POA/NEXT OF KIN IF PATIENT IS UNABLE OR UNWILLING TO COMPLETE THIS FORM:

Person Contacted: _____ Date/Time: _____

Person Contacted: _____ Date/Time: _____

Admission Assessors, House Supervisors, and Mental Health Tech- document any pertinent medical information, including patient status, report given, and intervention.

DATE AND TIME ALL ENTRIES:

_____/_____

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