LAKESIDE
BEHAVIORAL HEALTH SYSTEM

Patient Identification

HEALTH QUESTIONNAIRE FORM

Patient Name: _____ Date: _____

Name of Person Completing Form: _____ Relationship: _____

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: _____

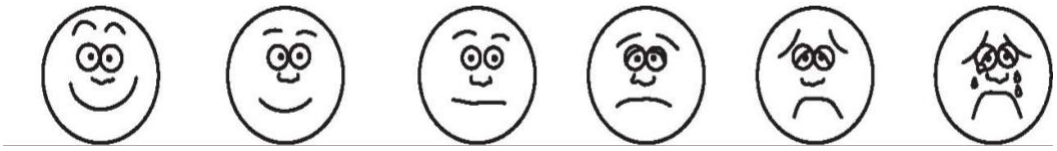
8. **Other *current* medical conditions:** **ALLERGIES (includes medications, foods, etc)**_____

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)		

How strong is your pain?

No pain **Quite a lot** **Worst Pain Imaginable**

0 1 2 3 4 5 6 7 8 9 10



No hurt **Hurts Little bit** **Hurts little more** **Hurts even more** **Hurts whole lot** **Hurts worst**

FOR STAFF USE ONLY

Blood glucose_____ (if patient is Insulin-dependent diabetic)

After review of medical- screen answers, what actions were taken by the triage staff:

_____

Reviewed By Nursing: _____Date/Time: _____

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

Date/Time:_____ **Triage Staff:_____** (signature)

Date/Time: _____ N**ARC Assessor**: _____ (signature)

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: _____

NARC Assessors, House Supervisors, and Community Counselors - document any pertinent information, including: Patient Status, Report Given, and Intervention.

DATE AND TIME ALL ENTRIES: ☐ **N/A** ☐ **Code Yellow** ☐ **Code Assist** ☐ **Information Provided to LIP**

_____/_____

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