Alberta Health Services | Covenant Health

Affix patient label within this box

Data Base 1

1. Reason for appointment / admission

____

2. _______________________________________

In the following selections, please check boxes and / or circle your answers

3. Health History

☐ jaw / neck problems
☐ seizures
☐ stroke
☐ blackouts
☐ rheumatic fever
  ☐ bleeding problems
  ☐ blood clots
☐ anemia
☐ heart problems
  ☐ chest pain / angina
  ☐ heart attack
☐ high blood pressure
	☐ Without stopping, can you climb
	  ☐ 10 or more stairs
	  ☐ less than ten stairs
	☐ lung problems
	  ☐ bronchitis
	  ☐ TB
	  ☐ shortness of breath
	  ☐ sleep apnea
	  ☐ asthma requiring hospitalization
	☐ stomach / bowel problems
	  ☐ acid taste when lying down
	☐ kidney / bladder problems
	☐ joint / bone problems
		☐ steroids (eg: Prednisone, Cortisone)
		☐ diabetes
		☐ thyroid problems
		☐ hepatitis / jaundice
		☐ HIV / AIDS
		☐ radiation / chemotherapy treatments
		☐ depression
		☐ mental illness
		☐ weight gain / loss
		  ☐ conditions that run in the family (eg. Muscular dystrophy / thalassaemia)
		☐ other ______________

If you have checked any of the above boxes, please **describe your symptoms** and how long you have had them

3. Allergies: Please list drugs, food and others and your reaction (eg: rash, fever, hives, swelling):

ALLERGIC TO	REACTION	ALLERGIC TO	REACTION

4. Previous hospitalizations, surgeries, and tests:

REASON	WHEN	WHERE

Have you ever received blood products? ☐ Yes ☐ No   Reactions? ☐ Yes ☐ No

Have you, or a family member, ever had a reaction to anaesthetics? ☐ Yes ☐ No

Explain: _______________________________________

5. Do you smoke? ☐ Yes ☐ No

Quit when? ______________ # of years ______________ Packs / day ______________

Do you drink alcohol? ☐ Yes ☐ No   How much? ______________ How often? ______________

Do you use street drugs? ☐ Yes ☐ No   Type ______________

6. First day of last menstrual period ______________ Are you pregnant? ☐ Yes ☐ No

Alberta Health Services | Covenant Health

Affix patient label within this box

Data Base 2

7. Medications:
Please list ALL your medications. Include prescriptions (eg: inhalers, sleeping pulls, birth control pills, patches) and over-the-counter medications (eg: aspirin, cold/allergy preparations, laxatives, vitamins, herbal/alternative medications):

DRUG NAME	DOSE AMOUNT	TIMES TAKEN		DRUG NAME	DOSE AMOUNT	TIMES TAKEN

8. Daily Living: Please check boxes for your answers:

Language: ☐ English ☐ Other ________________

Religion: ________________________________

Diet: ☐ regular ☐ special
Type of diet ______________________

Dental: ☐ no problems
☐ denture – ☐ upper ☐ lower ☐ partial
☐ capped teeth Comments __________

Sight: ☐ no problems ☐ glasses ☐ contacts
☐ artificial eye ☐ blind
Comments ______________________

Hearing: ☐ no problems ☐ impaired
☐ hearing aid ☐ deafness
Comments ______________________

Walking: ☐ no problems ☐ assisted
☐ prosthesis Comments ____________

Special customs: __________________________

Do you live alone? ☐ Yes ☐ No

With whom do you live? ____________________

Plans to go home:
a. Who will take you home? ____________
b. Do you have help at home? ☐ Yes ☐ No
Comments __________________________

Do you receive any of these services:
☐ Social Services ☐ Home Care ☐ PT
☐ Meals on Wheels ☐ DATS ☐ OT
☐ Home Oxygen Therapy ☐ Hired Services
☐ Day Program ☐ Community Mental Health
☐ other ______________________________

9. Other Comments

Date: ______________________ Information provided by: ______________________________
Relationship to patient: ______________________________

Thank you for your assistance in completing the Data Base. This information may be shared with other health institutes or professionals involved in your care.

For Health Care Professional's Use: T____ P____ R____ BP____ Ht. (cm) _____ Wt. (kg) _____ BMI_____

Comments ____

____ Signature ______________________________

Date ____________________ (Signature of Health Care Professional)

Admission: Date: ___________ Has any of this information changed? ☐ Yes ☐ No LMP ______________

Explain: ____

Date ___________________ Signature ______________________________
(Signature of Health Care Professional)