Patient Name: ________________________________

MR #:______________________________________

Creek General Hospital (Multidisciplinary form)

Initial Assessment Form (to be filled for initial patients only)

For the Department of Medicine (to be filled by Doctor)

Date: __________ Weight: ___________ (Kg) Pulse: ____________/min. Height ___________ cm
BP_________ mmHg Temperature: ___________ C Respiration ______________________ / min

PRESENTING COMPLAINTS & HISTORY OF PRESENT ILLNESS:

Patient Age (Yrs.) __________	Allergies Yes ☐ No ☐	Patient at risk of fall Y/N
Marital status ___________	if yes please specify _____________	HEP B or C positive Y/N
Vaccination: Hep B ☐	_______________________________	**Primary Physician Name & Designation**
Childhood vaccination ☐	History of blood transfusion Y/N	

HISTORY OF PAST ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ TB

Presenting Complaint and History of presenting Illness:

HISTORY OF PREVIOUS HOSPITALIZATION & CURRENT MEDICATIONS

YEAR	REASON	CURRENT MEDICATION WITH STRENGTH

OBSTERTRICS AND MENSTRUAL HISTORY ____
____

FAMILY HISTORY: ____

GENERAL PHYSICAL EXAMINATION: ____

ABDOMINAL EXAMINATION	RESPIRATORY EXAMINATION

CRDIOVASCULAR EXAMINATION	NEUROLOGICAL EXAMINATION

SYSTEMIC REVIEW: if patient currently have any of the following symptoms or conditions (Check yes)

General: ☐ Nothing in this group
- ☐ Weight loss – How much________lbs.
- ☐ Loss of Appetite
- ☐ Fever
- ☐ Night Sweats
- ☐ Fainting Spells

Skin: ☐ Nothing in this group
- ☐ Rash
- ☐ Skin infections
- ☐ Ulcers or sores
- ☐ yellowing of the skin
- ☐ Eczema, psoriasis, other _______________

Neurological: ☐ Nothing in this group
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Weakness
- ☐ Seizures
- ☐ Stroke
- ☐ Paralysis
- ☐ Decreased sensation
- ☐ Difficulty with speech
- ☐ Dizziness

Psychiatric: ☐ Nothing in this group
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Phobias, panic attack

ENT
- ☐ Hearing Loss
- ☐ Allergic Rhinitis

Digestive: ☐ Nothing in this group
- ☐ Loss of appetite
- ☐ Difficulty in swallowing
- ☐ Early satiety (fill up easy)
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Dark, tarry stools
- ☐ Abdominal pain
- ☐ Painful bowel movements

Urinary: ☐ Nothing in this group
- ☐ Burning micturition
- ☐ Weak urine stream
- ☐ Hematuria
- ☐ Gas or stool in urine
- ☐ Poor control or dribbling
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Testicular mass
- ☐ Get up at night to urinate - Number of times per night __________________

Endocrine: ☐ Nothing in this group
- ☐ Heat or cold intolerance
- ☐ Excessive thirst
- ☐ Excessive urination

EYE
- ☐ Red Eye
- ☐ vision loss /double vision

Cardiovascular: ☐ Nothing in this group
- ☐ Chest pain
- ☐ Palpitations
- ☐ Heart valve problems
- ☐ Calf pain while walking
- ☐ Leg swelling

Respiratory: ☐ Nothing in this group
- ☐ Chronic cough
- ☐ hemoptysis
- ☐ Shortness of breath with activity
- ☐ Shortness of breath on lying flat
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia

Musculoskeletal: ☐ Nothing in this group
- ☐ Joint pain
- ☐ Arthritis
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Leg pain on walking
- ☐ Leg pain at rest
- ☐ H/O Fractures ____________________

Hematologic, Lymphatic: ☐ Nothing in this group
- ☐ Prior blood transfusion
- ☐ Easy bleeding or bruising
- ☐ Use of anticoagulants drugs
- ☐ Swollen lymph nodes

PROVISIONAL DIAGNOSIS

INVESTIGATIONS

TREATMENT PLAN

DOCTOR NAME & DESIGNATION