Addressograph

CURRENT SYSTEM ASSESSMENT

ALLERGIES & REACTION: (if known allergies, state in comments and include type of reaction) ☐ Yes ☐ No

Comments:
_____
_____

Initials:

GASTROINTESTINAL: IPN ☐ Yes ☐ No Bleeding ☐ Yes ☐ No Bowel Movements (BM) Q ___ days Last BM: _____ Hx of Constipation ☐ Yes ☐ No	Hx of Diarrhea ☐ Yes ☐ No Frequency: _____ Hx of Nausea ☐ Yes ☐ No Hx of Vomiting ☐ Yes ☐ No

Comments:
_____
_____

Initials:

GENITOURINARY: IPN ☐ Yes ☐ No Dysuria ☐ Yes ☐ No Frequency ☐ Yes ☐ No Hematuria ☐ Yes ☐ No Hx of urinary tract infection ☐ Yes ☐ No	Incontinence ☐ Yes ☐ No Indwelling catheter ☐ Foley ☐ Suprapubic Nocturia ☐ Yes ☐ No Retention ☐ Yes ☐ No

Comments:
_____
_____

Initials:

HEARING: IPN ☐ Yes ☐ No Able to hear normal conversations? ☐ Yes ☐ No Deafness ☐ Right ear ☐ Left ear	Hearing Aids ☐ Right ear ☐ Left ear Tinnitus ☐ Right ear ☐ Left ear

Comments: _____
_____

Initials:

INTEGUMENTARY: IPN ☐ Yes ☐ No Bruising/Petechia ☐ Yes ☐ No Burn(s) ☐ Yes ☐ No Jaundice ☐ Yes ☐ No	Rash ☐ Yes ☐ No Skin Condition: ☐ Dry ☐ Thin ☐ Scaly Laceration(s) ☐ Yes ☐ No

Comments:
_____
_____

Initials:

MUSCULOSKELETAL: IPN ☐ Yes ☐ No Height: _____ Weight: _____ Amputation ☐ Yes ☐ No Cast/Splint ☐ Yes ☐ No Decreased mobility ☐ Yes ☐ No	Decreased strength ☐ Yes ☐ No Deformities ☐ Yes ☐ No Joint Pain ☐ Yes ☐ No ROM limited ☐ Yes ☐ No Swelling ☐ Yes ☐ No
Comments: _____ _____	
Initials:	
NEUROLOGICAL: IPN ☐ Yes ☐ No Decreased LOC ☐ Yes ☐ No Hx of headache ☐ Yes ☐ No Impaired Speech ☐ Yes ☐ No Lethargic ☐ Yes ☐ No	Increased Confusion ☐ Yes ☐ No Light-headedness/Vertigo ☐ Yes ☐ No Numbness/Sensory Loss ☐ Yes ☐ No Seizure/Blackout(s) ☐ Yes ☐ No Tremor ☐ Yes ☐ No
Comments: _____ _____	
Initials:	
REPRODUCTIVE: IPN ☐ Yes ☐ No Bleeding/discharge ☐ Yes ☐ No ☐ N/A Menstrual problems ☐ Yes ☐ No ☐ N/A	Menopausal ☐ Yes ☐ No ☐ N/A Prostate problems ☐ Yes ☐ No ☐ N/A
Comments: _____ _____	
Initials:	
RESPIRATORY IPN ☐ Yes ☐ No Cough ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No	Hemoptysis ☐ Yes ☐ No Sputum ☐ Yes ☐ No
Comments: _____ _____	
Initials:	
SLEEP PATTERN: IPN ☐ Yes ☐ No Rituals (if yes, document in comments) ☐ Yes ☐ No	Usual bedtime? _____
Comments: _____ _____	
Initials:	

VISION: IPN ☐ Yes ☐ No Blind ☐Right eye ☐ Left eye Blurred Vision ☐Right eye ☐ Left eye	Glasses/Other ☐ Yes ☐ No Normal PERLA ☐ Yes ☐ No
Comments: _____ _____	
Initials:	

ADDITIONAL ASSESSMENTS:		
Braden Scale completed?	☐ Yes	☐ No
Fall Risk Screening Tool completed?	☐ Yes	☐ No
Mobility and Transfer Assessment completed?	☐ Yes	☐ No
Suicide Risk Assessment completed?	☐ Yes	☐ No
Geriatric Depression Scale (GDS) completed?	☐ Yes	☐ No
Pain Assessment completed?	☐ Yes	☐ No
Elopement Risk Assessment completed?	☐ Yes	☐ No
Comments: _____ _____		
Initials:		