### St. Vincent Hospital

**Date:**

**Why is patient here today?**

<table>
<thead>
<tr>
<th>Patients Age</th>
<th>Ht. Actual/Stated</th>
<th>Wt. Actual/Stated</th>
</tr>
</thead>
</table>

**Addressograph**

**St. Vincent Hospital**

**784448880**

**1101**

**PATIENT HEALTH PROFILE**

**13F1**

**Date**

**Why is patient here today?**

**Patient's Age**

**Ht.** Actual/Stated **Wt.** Actual/Stated

**ALLERGIES** (medication, food, latex, tape, etc.)

**TYPE OF ALLERGIC REACTION**

**CURRENT MEDICATIONS:** (include herbals/vitamins, prescribed and/or over-the-counter, taken regularly or as needed)

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Amount/How Often</th>
<th>Reason for Taking</th>
<th>Last Time Taken</th>
</tr>
</thead>
</table>

**PATIENT'S MEDICAL HISTORY:** (circle any past/current patient problems)

- **Awake / Oriented / Confused / Unresponsive**
- **Skin / Rash**
- **Eyes, ears, nose, mouth, sinus, throat**
- **Diabetes / Immune System / Thyroid / Cancer**
- **Pneumovax Vaccine / Date**
- **TB / Positive Skin Test / Date of Last Test**
- **Date of Last Tetanus Shot**
- **Pneumovax Vaccine / Date**
- **Yearly Flu Shot / Date**

**Factors that may affect learning:**

- **Language if other than English**
- **Previous hospitalization**
- **Anxiety**
- **Patient learns best by:**
  - Reading
  - Verbal instruction
  - Practicing
  - Talking
  - Watching
  - Other

**Name of person with patient:**

**Relationship:**

**Who will help patient at home:**

**Relationship:**

**For Staff Use Only:**

**Comments:**

**Patient Risk for Falls:**

**Low Risk**

**High Risk**

**Interventions in Place:**

**No**

**Yes**

**Mental Status:**

**Signature, Date, Time of Review:**

**PREVIOUS SURGERIES/PROCEDURES**

**IF PATIENT IS UNDER 18 YEARS OLD:**

- **Does patient exhibit age-appropriate behaviors?**
  - **No**
  - **Yes**

- **For children less than 5 years old: birth weight**

- **Premature?**
  - **No**
  - **Yes**

- **Immunizations up to date?**
  - **No**
  - **Yes**

- **Verified by**

- **Patient/Family problem with anesthesia?**
  - **No**
  - **Yes**

  **Social/Environmental**

- **Has patient experienced personal issues or life changes recently?**
  - **No**
  - **Yes**

- **Does patient have any religious/spiritual needs while here?**
  - **No**
  - **Yes**

- **Does the patient have financial concerns regarding this visit?**
  - **No**
  - **Yes**

- **Does patient have difficulty getting medications and/or supplies?**
  - **No**
  - **Yes**

- **Does patient have a dietary preference?**
  - **No**
  - **Yes**

- **Does patient have concerns about caring for self or family?**
  - **No**
  - **Yes**

- **Patient Risk for Falls:**
  - **Low Risk**
  - **High Risk**

- **Interventions in Place:**
  - **No**
  - **Yes**

- **Mental Status:**

- **Signature, Date, Time of Review:**

- **TB / Positive Skin Test / Date of Last Test**

- **Date of Last Tetanus Shot**

- **Pneumovax Vaccine / Date**

- **Yearly Flu Shot / Date**

- **Alcohol**

- **drinks per day**

- **Drug Use**

- **Smoking**

- **packs per day**

- **years**

- **Implants / Pins / Shrapnel**

- **IV Access: Hickman, Portocath, PICC**

- **Other IV Access:**

- **Blood / Bleeding / Stroke**

- **Difficulty Walking / Frequent Falls**

- **Alcohol**

- **drinks per day**

- **Drug Use**

- **Sleep too much / too little**

- **Smoking**

- **packs / day**

- **years**

- **TB / Positive Skin Test / Date of Last Test**

- **Date of Last Tetanus Shot**

- **Yearly Flu Shot / Date**

- **Alcohol**

- **drinks per day**

- **Drug Use**

- **Smoking**

- **packs / day**

- **years**

- **Implants / Pins / Shrapnel**

- **IV Access: Hickman, Portocath, PICC**

- **Other IV Access:**

- **Anxiety**

- **Previous hospitalization**

- **Anxiety**

- **Patient learns best by:**
  - Reading
  - Verbal instruction
  - Practicing
  - Talking
  - Watching
  - Other

- **Name of person with patient:**

- **Relationship:**

- **Who will help patient at home:**

- **Relationship:**

- **Completed by:**

- **Relationship:**

- **Comments:**

- **Patient Risk for Falls:**
  - **Low Risk**
  - **High Risk**

- **Interventions in Place:**
  - **No**
  - **Yes**

- **Mental Status:**

- **Signature, Date, Time of Review:**
KEY POINTS

1. Recurrent patient's PHP may be copied and kept on the unit for subsequent visits.
2. ACTUAL height and weight should be obtained if possible.
3. If there is inadequate space to list current medications and previous surgeries, record the complete list onto the History & Physical form or other hospital approved form.
4. If patient has positive signs and symptoms for TB (persistent cough, anorexia, bloody sputum, night sweats) the patient will be given a mask to wear and offered patient education.
5. Refer to Growth and Development section on Pediatric Patient Health Profile if further information regarding age appropriate behaviors is needed.
6. Any patient requiring nursing care must also have a completed interdisciplinary Patient Teaching Plan/Patient Response Record.
7. Consults should be documented on the Interdisciplinary Consult Tool.
8. Factors that may indicate high risk for falls are: patient's age, previous stroke, difficulty walking, frequent falls and confused. These factors are in bold print on the form. Other factors indicating an increased risk for falls include: non-compliance with safety instructions, elimination problems, weakness, unsteady gait or orthostatic hypotension. Patients at high risk for falls are to be accompanied between departments.