

Surgical Specialists and Vein Institute of New Jersey

Admission Assessment Form

Read each question and circle the answer which applies

CONSTITUTIONAL

Good general health lately	yes	no
Recent weight change	yes	no
Fever	yes	no
Fatigue	yes	no
Pain	yes	no

EYES

Blurred/double vision	yes	no
Poor vision, contacts, glasses	yes	no
History of eye disease	yes	no

EARS/NOSE/MOUTH/THROAT

Ringing in the ears	yes	no
Change in hearing	yes	no
Deafness/hearing aid	yes	no
Sore throat	yes	no
Trouble swallowing	yes	no

CARDIOVASCULAR

History of rheumatic fever	yes	no
History of heart attack	yes	no
History of stroke	yes	no
History of CHF or chest pain	yes	no
Palpitations	yes	no
History of hypertension	yes	no
History of phlebitis/blood clots	yes	no
Do you use oxygen at home	yes	no?
Do you have a pacemaker	yes	no
Swelling of legs/ankles	yes	no
Varicose veins	yes	no

RESPIRATORY

Frequent colds	yes	no
Difficulty breathing, shortness of breath	yes	no
Cough	yes	no
Asthma	yes	no
Hay fever	yes	no
Chronic Obstructive Pulmonary Disease	yes	no
Tuberculosis (TB)	yes	no

GASTROINTESTINAL

Heartburn	yes	no
Vomiting	yes	no
Constipation	yes	no
Diarrhea	yes	no
Blood in stool	yes	no
Peptic ulcer	yes	no
Abdominal pain	yes	no

INTEGUMENTARY (SKIN)

Rash	yes	no
History of masses	yes	no
Birthmarks, warts, lumps, nodules	yes	no
Slow to heal after cuts	yes	no
Bleeding/bruising tendency	yes	no
Hair growth	yes	no
Gangrene	yes	no

MUSCULOSKELETAL

Leg pain (rest or walking)	yes	no
Back pain	yes	no
Joint pain or swelling	yes	no

ENDOCRINE

Excessive thirst	yes	no			
Thyroid disease	yes	no			
Heat/cold intolerance	yes	no			
Diabetes	yes	no	Do you monitor your blood sugar	yes	no
	Controlled?	yes	no		
	Medication?	yes	no		
	Do you monitor your blood sugar?	yes	no		

PSYCHIATRIC

Depression/anxiety	yes	no
Change in memory	yes	no

IMMUNOLOGIC

Rheumatoid arthritis	yes	no
Lupus	yes	no
Sickle cell disease	yes	no
Scleroderma	yes	no
Vasculitis	yes	no
HIV/AIDS	yes	no

NEUROLOGICAL

Spinal cord injury	yes	no
Seizures	yes	no
Tremors	yes	no
Numbness/tingling	yes	no
Difficulty with balance	yes	no
Paralysis	yes	no
Aphasia	yes	no
Changes in sensation	yes	no

Describe-_____

HEMATOLOGIC/LYMPHATIC

Blood borne disease	yes	no
Anemia	yes	no
Blood abnormalities	yes	no

GENITOURINARY

Renal disease/dialysis	yes	no
Difficulty with urination	yes	no
Frequent/burning urination	yes	no
Incontinence	yes	no
Blood in urine	yes	no
Menses/vaginal bleeding/pain	yes	no
Testicular/prostate problems	yes	no
History of STD's	yes	no

OTHER

History of cancer	yes	no
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Type of Cancer-_____

Chemotherapy	yes	no
Radiation treatments	yes	no
Evidence of abuse or neglect	yes	no

ADDITIONAL INFORMATION

FOR OFFICE USE ONLY

Reviewed and concur with above History & ROS
YES OR NO

Exam Dictated Yes or No

NURSE INITIALS _____

PHYSICIAN SIGNATURE _____

DATE _____

DATE _____