Alberta Health Services | Covenant Health

Patient Name:	
DOB:	Sex:
PHN:	
Address:	
Phone: (Home): ( ) -	

Data Base 1

CHA-20 - July 96

1. Reason for appointment / admission ______________________

____

In the following sections, please check (✓) boxes and / or circle your answers:

2. 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** Reaction? ◯ **Yes** ◯ **No**

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

Explain: ______________________

5. Do you smoke?

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**

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7. **Medications:** Please list **ALL** your medications. Include prescriptions (eg: inhalers, sleeping pills, 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 and / or circle 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
☐ prothesis 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?

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 institutions or professionals involved in your care.

For Health Care Professional's Use: T ____ P ____ R ____ BP ____ Ht.(cm) ____ Wt.(kg) ____ BMI ____

Comments ______

______ Signature ______
(Signature of Health Care Professional)

Admission: Date: ______ Has any of this information changed? ◯ **Yes** ◯ **No** LMP ______

Explain: ______

Date ______ Signature ______
(Signature of Health Care Professional)