COUNTY OF LOS ANGELES- DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE OLDER ADULT SERVICES

NURSING OLDER ADULT INITIAL ASSESSMENT

SOCIAL HISTORY (Please Circle)

Informant _____ Reliability: Good ____ Bad ____

Nutrition: Meals/day _____
MOW ____ Freq. _____day/week _____
Restaurant __ Freq. _____ day/week _____
Sr. Nutr. ___ Freq. _____ day/week _____
Home Prep. _ Self _____Other _____

Food group eaten daily: Dairy __ Fruit/Veg. __ Meat/Eggs __ | Bread ___
Special Diet _____

Exercise: None ___ 15 mins. / more ___
Type & Frequency _____

Interests: Reading ___ Church ____ Volunteer ____ Hobbies ____
Sr. Ctr. ____ ADC ____ ADHC ____ Family ____
Friends ____ Recluse ____ Other _____

Sex: Single Partner __ Multiple Partner __ Frequency __ None __

Sleep Hrs./Night ___ Naps __ Morning Fatigue __ Noc. Awakening __
Hrs./24 hrs. ___ Early AM riser ____ Diff. Falling sleep _____
Uses Sleeping Pill _____ Name/dose _____

Transportation: Current Driver's Lic. Yes _ No _ Drive car _ Doesn't go out _
Ride with Friend/family ___ Bus _ Cab _ Dial-a-ride _ Walk _
ACCESS _____

Significant change/Recent Loss/Losses: Spouse ____ Family ____ Friend ____ Pet ____ Job ____
Other: _____

Advanced Directive None ____ Written ____ Oral ____ Details____

CHIEF COMPLAINT:

_____
_____
_____
_____
_____
_____
_____
_____

Name: _____ **Date:** _____

Mis # _____ **RN Signature:** _____

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PAST MEDICAL HISTORY

Any history of:			Description
Allergies (all) _____	Y	N	_____
HTN _____	Y	N	_____
CVA/TIA _____	Y	N	_____
DM _____	Y	N	_____
MI/ Angina/ CHF/ CAD _____	Y	N	_____
Lung Disease (bronchitis, Emphysema, asthma, pneumonia) _____	Y	N	_____
Liver Disease (Hepatitis, jaundice, Cirrhosis) _____	Y	N	_____
Anemia (Iron, B12) _____	Y	N	Req. Transfusion_____
Thyroid _____	Y	N	_____
Diverticulosis or–itis _____	Y	N	_____
Ulcer/Reflux _____	Y	N	_____
GB _____	Y	N	_____
ID _____	Y	N	_____
V.D. _____	Y	N	_____
TB _____	Y	N	_____
DJD _____	Y	N	_____
Gout _____	Y	N	_____
Cancer _____	Y	N	_____
Cataract _____	Y	N	_____
Glaucoma _____	Y	N	_____
Seizure _____	Y	N	_____
Hernias _____	Y	N	_____
Prostate _____	Y	N	_____
Phlebitis _____	Y	N	_____
Parkinson _____	Y	N	_____
Other _____	Y	N	_____

Medical Hospitalization (location/dates/reason) _____

Fracture (sites and dates)

_____

_____

Surgical Procedures_____

FAMILY HISTORY

Mother Age: _____ Alive ___ Deceased ___ Disease:_____

Father Age: _____ Alive ___ Deceased ___ Disease:_____

Siblings: Number Alive & Well _____M _____ F

Number Deceased _____M _____ F

Diseases _____

Children: How many ____ Alive ____ Decreased ___ Disease: _____

Where Location: _____

Diseases _____

Name: _____ **Date:** _____

Mis # _____ **RN Signature:** _____

SSG:lw 10-08

COUNTY OF LOS ANGELES- DEPARTMENT OF MENTAL HEALTH
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REVIEW OF SYSTEMS

GENERAL: Last CPE _____
Fatigue _____ Y N
Fever _____ Y N
Weight Change _____ Y N
Sweating Spells/Nights _____ Y N
Immunizations _____
BCG ___ Flu ___ Tetanus__ Pheumovax ___
Last PPD _____
Other _____

SKIN
Severe Headache _____ Y N
Itch/Dry _____ Y N
Hair loss _____ Y N
Other _____ Y N

HEAD
Severe Headache _____ Y N
Dizzy/Unsteady/Vertigo _____ Y N
Trauma/LOC _____ Y N
CT Scan/Head _____ Y N

EYES
Failing Vision _____ Y N
Pain _____ Y N
Double Vision/Floaters _____ Y N
Glasses/Contacts _____ Y N
Last Eye Exam _____
Dr. _____

EARS
Hearing Loss _____ Y N
Ringing _____ Y N
Pain/Discharge _____ Y N
Hearing Aid _____ Y N

NOSE
Chr. Obstr. _____ Y N
Nosebleeds _____ Y N
Congestion_____ Y N

MOUTH/THROAT
Toothache _____ Y N
Sore Gums _____ Y N
Sore Tongue _____ Y N
Sore Throat _____ Y N
Dif. Swallowing/Pain _____ Y N
Hoarseness/Voice Change Y N
Dentures _____ Y N
Last Dental Exam _____
DDS _____

NECK
Swelling/Pain _____ Y N
Stiffness _____ Y N

CHEST/LUNGS: Last CXR _____
Difficult Breathing _____ Y N
At Rest _____ Y N
With Activity ___ Y N
Sit up to Breath _ Y N
Wheezing _____ Y N
Chronic Cough _____ Y N
Coughs Up Blood _____ Y N
Sputum _____ Y N
Color _____

HEART
Chest Pain at rest _____ Y N
On Effort _____ Y N
Ankles Swell _____ Y N
Any Defects/Murmurs ____ Y N
Pacemaker _____ Y N
Type _____
Rapid Heart Beat _____ Y N
Irregular H.B. _____ Y N
Palpitation _____ Y N
Work-Up _____

Name: _____ **Date:** _____

Mis # _____ **RN Signature:** _____

COUNTY OF LOS ANGELES- DEPARTMENT OF MENTAL HEALTH
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REVIEW OF SYSTEMS (Continued)

GASTRONINTESTINAL

Appetite ↑↓ _____ Y N
Nausea/Vomiting _____ Y N
Vomit Blood _____ Y N
Heartburn _____ Y N
Diarrhea _____ Y N
Constipation _____ Y N
Hemorrhoids _____ Y N
Stools Blood/Black/Clay _____ Y N
Bloating/Gas _____ Y N
Incontinence _____ Y N
Abdominal Pain _____ Y N
Last Rectal Exam _____
Work-Up _____

GENITOURINARY

Frequent Urination _____ Y N
Night Urination _____ Y N
Pain with Urination _____ Y N
Blood with Urine _____ Y N
Bed Wetting/Incontinence ___ Y N
Retention _____ Y N
Urgency (holding) _____ Y N
Hesitancy (starting) _____ Y N
Pad or Diaper _____ Y N
Work-Up _____

FEMALES

Bleeding _____ Y N
Discharge _____ Y N
Vaginal itch/Rash/Lump _____ Y N
Breast Lumps/Pain/DC _____ Y N
Last Mammogram _____
Last Pelvic/PAP _____
Menopause age _____
Hormones (name & duration) _____

NERVIOUS SYSTEM

Falls _____ Y N
Faints _____ Y N
Weakness/Paralysis _____ Y N Site: _____
Memory Loss _____ Y N
Speech Changes _____ Y N
Shaking/Tremor _____ Y N
Other _____

MUSCULOSKELETAL

Numbness/Tingle _____ Y N Site: _____
Muscle Jerking _____ Y N
Limited Motion/Asymmetry __ Y N
Joint Trouble _____ Y N
Varicose Veins _____ Y N
Stiffness-Morn. _____ Y N

JOINT SWELLING/PAIN

Neck _____ Y N
Shoulder _____ R L
Elbow _____ R L
Wrist _____ R L
Hand _____ R L
Back _____ Upper ____ Mid ____ Lower ____
Hip/Leg/Knee _____ R L
Ankle/Foot _____ R L
Pain on walking _____ Y N Why: _____
Toenails cut: Pt ___ Pod___ Other ___ Not Done ___
Shoe type: Support ____ Hi-heel ___Worn down___
Other _____

OTHER DETAILS:

Name: _____ **Date:** _____

Mis # _____ **RN Signature:** _____

COUNTY OF LOS ANGELES- DEPARTMENT OF MENTAL HEALTH
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PHYSICAL EXAMINATION

VITAL SIGNS: Ht ___ Wt ____ Resp. ___ /min. Temp. ___°

BP Apical **Pulse** ____ /min.

Sitting R ___/___ L ___/___ Rad Pulse _____ /min.

Standing R ___/___ L ___/___ Rad Pulse _____ /min.

Lying R ___/___ L ___/___ Rad Pulse _____ /min.

General Assessment _____ Handed R_ L _ Hygiene _____

_____

_____

_____

SKIN: NL __ Abn.__ Turgor __ Dry __ Bruises___ Other ___ Susp. Malign. __ Susp. Benign __

Lesion _____ Location _____

HEAD: AT _ NC ___ Abn _____

EARS: NL _ TM Clear ___ Abn _____

Can not hear normal voice _____ R _____ L _____

Can not hear finger rub _____ R _____ L _____

Impacted cerumen _____ R _____ L _____

Wears Hearing Aid _____ R _____ L _____

Other _____

NOSE: NL ____ Septum Central ____ Abn _____

MOUTH: NL ____ Poor Hygiene ___ Teeth Normal __ Poor Repair _ Edentulous _

Partial ____ Denture upper __ Lower __ Sores under denture _____

Ill fitting dentures __ Mucous membrane NL __ Abn_____

TONGUE: NL ____ Deviated To R _ L _ Papillae: NL _ Dry _ Smooth & Beefy __

PHARYNX: NL ____ Abn _____ VOICE: NL __ Abn _____

EYES: NL ____ Abn_____

Vision grossly WNL _____ Abn _____ R _____ L _____

Can not read Newsprint ___ R _____ L _____

Wears glasses __ Contacts _ Bifocals __ R _____ L _____

Cataract No __ Aphakia Yes __ R _____ L _____

Pupils: PERRLA NL __ Abn _____ R _____ L _____

Fundus NL __ Not visualized _ Abn _____ R _____ L _____

EOM Full & Intact __ Abn _____ R _____ L _____

Arcus Senilis Present __ Absent ____ R _____ L _____

Conjunctiva NL __ Abn _____ R _____ L _____

Lids (Upper & Lower) NL __ Abn _____ R _____ L _____

Visual Fields NL __ Abn _____ R _____ L _____

NECK: Supple ___ Full ROM _ JVD _ Carotid Bruit R __ L __ Abn _____

THYROID: NL _____ Non palpable _____ Abn _____

LYMPH: NL _____ Abn _____ Site _____

Name: _____ **Date:** _____

Mis # _____ **RN Signature:** _____

COUNTY OF LOS ANGELES- DEPARTMENT OF MENTAL HEALTH
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PHYSICAL EXAMINATION (Continued)

BREAST: NL _____ Abn _____
Nipples Everted _____ Inverted _____
Tenderness No ____ Abn _____ R _____ L _____
Asymmetry No ____ Abn _____ R _____ L _____
Lump No ____ Abn _____ R _____ L _____
Skin NL ____ Abn _____ R _____ L _____

CHEST: NL __ Contour __ Non-tender ___ Abn: __ Barrel ___ Excavation ___
Other: _____

LUNG: A&P: NL __ Abn ____ Wheeze ___ Rhonchi _____ Rale _____
Other & Location: _____

HEART: Apical Rate ___/min. Rhythm ___ RR ___ Reg. Irreg. ___ Irreg. Irreg. ___
Gallop_ Rub _ Murmur (location, intensity type) _____ Other:_____

PULSE: NL _____ Abn: _____
Normal Radial R _ L _ **Carotid** R _ L _ **Fem** R _ L _
Normal Pop R _ L _ **D.P.** R _ L _ **P.T.** R _ L _

ABDOMEN: Position of Exam: ___ ___ ___ ___ Soft ___ BS __ Distended___
Tender __ Guarded __ Bruit (location)__ Liver/Spleen NL __ Abn__
Ascites__
Mass _____ Scar _____

HERNIA: Absent ____ Present _____ Location _____
Non Reducible _____ Reducible _____ Tender ____ B.S. _____

MUSCULOSKELETAL:
NL __ Abn ____ Deformity _____

ROM: NI ___ Tenderness _____ Other _____

CVA: Non-Tender: ___ Tenderness___ Spinal/Column Contour NL ___ Abn ____

NEURO: WNL _ Abn _____ RAM WNL _ Abn _____ Tremor WNL _ Abn _____
CN WNL _ Abn _____ Gait WNL _ Abn _____ Speech WNL _ Abn _____
Motor Tone __/5 Abn Increase @ site ____ Decrease @ site ___
Strength ____/5 Abn Increase @ site _____ Decrease @ site ___

EXTREMETIES: NL __ DTR NL____ Edema Absent ____ Edema Amt. & Location _____
Clubbing ___ Cyanosis Absent ___ Cyanosis Amt. & Location _____
Toenails: Normal ___ Mycotic ___ Overgrown ___ Other _____

Name: _____ **Date:** _____

Mis # _____ **RN Signature:** _____

SSG:lw 10-08