MULTNOMAH COUNTY HEALTH DEPARTMENT

Initial Nursing Assessment: Social & Health History

Environmental/Basic Needs:

Home/Environmental Assessment: Maintenance: W/ x̄ Cleanliness: W/ x̄ Heating/Ventilation: W/ x̄
Water/Sewer: W/ x̄ *Phone available: W/ x̄ Food Storage/Refrig: W/ x̄ Food Prep Area: W/ x̄
*Firearms Secured: W/ x̄ Fire Prevention: W/ x̄ *Smoke Alarm: W/ x̄ Woodstove/Fireplace: W/ x̄
2nd hand smoke: W/ x̄ *Lead exposure: W/ x̄ *Exposure to toxins: W/ x̄ *Pets W/ x̄ * # of bedrooms/person: W/ x̄
☐ *check if environmental assessment is "per client report"; plan to visit home at subsequent visit.*
Notes:_____

Income Source *(List updates on Family Database)*	**Amount (optional)**
☐Job	$
☐TANF	$
☐Food Stamps	$
☐SSI	$
☐WIC	
☐Other	$
☐Other	$

Family Resources
Health Insurance: **see Family Database**
Housing: □ rent □ own _____
Transportation:_____
Childcare:_____

Cognitive Assessment
Education level:_____
Languages : _____☐ reads _____☐ reads _____☐ reads
Learning preference: ☐ reading ☐ talking ☐ video ☐ other_____

Physiological ☐ See Correspondence for Medical Records from_____

Review of Systems: *Check (√) Yes or No for client and immediate family members. Complete updates as needed in FP column if billing for family planning.*	Date Self Y	Date Self N	Date Family Y	Date Family N	Date ***FP*** Y	Date ***FP*** N	Year of occurrence and notes
General health (***hospitalizations, surgeries***, blood transfusions, ***cancer***, dental problems, nutrition, activity)							
Medications							
Allergies							
Cardiovascular (***heart attack***, ***stroke high BP***, other)							
Musculoskeletal (muscle, joint pain, other)							
Digestive (GI diseases, ulcers, Crohn's, other)							
Respiratory (asthma, TB, other)							
Blood/Lymphatic (anemia, sickle cell***, blood clots***, other)							
Endocrine (diabetes, other)							
Neurological (epilepsy, head aches, other)							
Urinary (kidney disease, chronic UTI, other)							
Sexually Transmitted Infections							
Skin							
Reproductive history	**See back**						
Substance Use	**See below**						

Substance Use ***Mark with a*** √	**Never**	**Hx <6mo**	**Current >6mo**
Alcohol			
Tobacco			□ See 5 A's
Drugs			

For current or history of use:
What products used?_____ETOH > 5 drinks/time____
Date of last use_____How much used_____
Client sees as problem?

Notes:

R.N. Signature _____Date _____

Key: W= Within Defined Limits
x̄ =Within Defined Limits Except
√ in ☐ indicates this option is true
Fill in blanks with information requested. Discuss any exceptions in notes fields provided.

Client Name_____
Date of Birth _____
Medical Record ID _____

Physiological continued…

Pregnancy History:

G_____ P_____T _____A_____ L____
Gravida, Para Term Abortion Living

Current Pg: EDD_____ PN Provider: See FDB Date started PN Care: _____
Delivery Site: _____ Childbirth education plans: _____ Baseline BP: _____

Lab Tests Completed
(Must assess bolded items)

	_____Hep B	_____Ultrasound	_____PPD	Other: _____
	_____HIV	_____Rubella	_____Blood type	Other: _____

Psychosocial

Maternal Role/Social Support: Planned Pg? Yes No FOB involved? Yes No
Feelings about Pg: _____Support People: _____ Labor Coach: _____
Family Violence: ☐History of Violence ☐ Current Violence ☐Physical ☐ Emotional ☐ Safety Plan Not Needed
Child Abuse: ☐Survivor ☐Perpetrator
Mental Health:
Client mental health hx W / x̄ Current Sx of depression/anxiety W / x̄ Coping Skills W / x̄ Self Esteem W / x̄
Family Mental health hx W / x̄ **Cognitive Assessment: see Front**

Health Related Behaviors

Maternal Nutrition: W / x̄ Pre-pg wt _____ or ☐see wt graph Folic Acid/PN Vitamins: W / x̄
Maternal Oral Health: W / x̄ Access to dental care: W / x̄ Plans to Breastfeed: ☐Yes ☐No
Knowledge/experience with BF:_____
Physical Activity/Exercise: W / x̄ Immunizations: W / x̄ **Substance Use: see front**

Notes:

Initials **Date** **Initials** **Date**

Initial Assessment Completed: ☐ Letter and Initial Assessment sent to P.N Provider for MCM on _____ (date)
☐ Client referred to provider for P.N. care on _____(date)

Reproductive History *(mandatory for family planning visits)*

Age at first period: _____ When was the 1st day of your last period? _____
Are our periods regular? Yes No Do you have bleeding between periods? Yes No
What kind of birth control do you use now? (including tubal ligation)_____
Contraceptive use since last LMP? Yes No When was your last pap smear? Date_____
Have you ever had an abnormal Pap smear? Yes No If yes, date of abnormal Pap smear? Date_____
Do you check your breast for lumps? Yes No If over 40, when was your last mammogram? Date_____
Have you ever been tested for HIV? Yes No If yes, Date_____ Results _____
How long have you been with your current partner(s)? _____ # of partners in last 3 months? _____
When was the last time you had sex? _____Are you having any vaginal symptoms? ☐Yes ☐ No
If yes, describe_____
Family Planning billing instructions: Review **yearly** sections entitled Review of Systems, Substance Abuse, Reproductive History and verify the following: ☐CHN reviewed and updated health hx **for any occurrence of heart attack, hypertension, stroke, blood clots, STIs, surgeries, major medical problems or medications used, including antibiotics.**

Initials Date Initials Date

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Client Name_____
Date of Birth _____
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