CEDAR CREEK HOSPITAL of Michigan

Patient Label

Walk In Assessment Triage Form

Patient Name: _____ Date of Birth: _____ Age: _____

Do you have any allergies to medication or food: _____

Medical Status	Yes	No	Medical Status	Yes	No
Urinary Tract Infection			Hypertension		
Asthma/COPD/ Shortness of breath			Incontinence		
Diabetes			Open Wound/ Wound Care		
Recent Falls			Headaches		
Heart Disease			Fracture		
Current Chest Pain			Recurrent Kidney Infections		
CVA (Stroke)			Pregnant		
Seizure Disorder			Special Equipment (CPAP)		
Current Detox Symptoms?			Explain:		

Are you currently experiencing any medical complications? □ NO □ YES (If yes, staff contact physician/nursing)

Do you currently take medication? □ NO □ YES

Did you bring the medication with you today? □ NO □ YES

If you know them, please list medications below:	

Communicable Disease Questionnaire

This brief questionnaire is a screening tool to help identify possible communicable diseases.

1. Do you currently have or have you ever had: OR Have you been vaccinated for:

Measles	□ NO □ Yes	Date: _____		□ NO □ Yes
Mumps	□ NO □ Yes	Date: _____		□ NO □ Yes
Rubella	□ NO □ Yes	Date: _____		□ NO □ Yes
Influenza	□ NO □ Yes	Date: _____		□ NO □ Yes
Chicken Pox	□ NO □ Yes	Date: _____		□ NO □ Yes
Hepatitis A	□ NO □ Yes	Date: _____		□ NO □ Yes
Hepatitis B	□ NO □ Yes	Date: _____		□ NO □ Yes
Hepatitis C	□ NO □ Yes	Date: _____		□ NO □ Yes
HIV	□ NO □ Yes	Date: _____		
Tuberculosis	□ NO □ Yes	Date: _____		

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2. Have you traveled internationally or abroad within the last 2 weeks? □ NO □ Yes

3. Are you now under the care of a physician or taking any medication for a communicable disease?
□ NO □ Yes (Please note any current treatment for any areas checked):_____

4. Have you had recent contact with someone with any of the above illnesses? □ NO □ Yes
If yes which one (s) and when: _____

5. Have you ever been tested for Tuberculosis? □ NO □ Yes If yes, when? (Date) _____

6. Have you ever been tested positive for TB? □ NO □ Yes
If yes, did you have a chest x-ray? □ NO □ Yes
Were you treated? □ NO □ Yes If yes, when? (Date):_____
What kind of treatment? _____

7. **Please check yes or no to ALL symptoms as they apply to you**:

Elevated Temperature or Fever	□ NO □ Yes	Unusual or Increased Tiredness or Fatigue	□ NO □ Yes
Productive cough (3 weeks or more)	□ NO □ Yes	Persistent Weight Loss without Dieting	□ NO □ Yes
Persistent Low Grade Fever	□ NO □ Yes	Night Sweats	□ NO □ Yes
Loss of Appetite	□ NO □ Yes	Swollen Glands, usually in the Neck	□ NO □ Yes

8. Do you have a history of MRSA? □ NO □ Yes
Do you have Active MRSA? □ NO □ Yes

FOR STAFF USE ONLY

Vital Signs: BP: _____ Pulse: _____ Respirations: _____ Temp: _____ O2 Sat.: _____

Breathalyzer: _____ Height: _____ Weight: _____

After review of answers, what actions were taken?
□ Physician Notified
□ None Needed
□ Actions Needed Explain: _____

Reviewed By: _____ _____ _____
Signature of Staff Date Time