FAITH COMMUNITY NURSE PATIENT RECORD

Date: _____ Office Visit ___ Home Visit ___ Telephone Call___ Other _____
Name: _____ Age: _____ DOB: _____ Gender: F ___ M ___
Address:_____
Partner Status: _____ Living Arrangement: _____
Referred by: _____ Reason: _____

Family Support: _____ Other Support: _____
Phone #: _____ Other Phone: _____Insurance Co: _____
Physician: _____ Other Provider: _____ _____SS#: _____
Emergency Contact: _____Address_____phone_____

Medical History

Height _____ Weight _____ BP L arm _____ R arm _____ Pulse _____ Respiration _____
Allergies: _____
Recent Illnesses:_____
Past History:_____
Surgical History:_____
Current Medications/Reason: _____
_____
Exercise Pattern: _____ Diet Pattern: _____

Lifestyle Risks:		**Stressors:**		**Family History:**		**Present Problem:**	
Smoke	___	Family	___	Cancer	___	Physical	___
Alcohol	___	Financial	___	Diabetes	___	Emotional	___
Drugs	___	Employment	___	Heart Disease	___	Spiritual	___
Obesity	___	Spiritual	___	Cholesterol	___	Social	___
Stress	___	Other _____		Alcohol	___		
Inactivity	___	_____		Other factors:	_____		

Coping Mechanisms:

_____

_____

Faith History: _____

Special concerns:_____

Advanced Directives: Living Will _____ Durable Power of Attorney _____ Location _____

NARRATIVE: _____
_____
_____

Client Response:_____

_____

Signature of FCN_____