**UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS**

**Functional Health Pattern Assessment: ADULT**

To be completed within 24 hours of hospital admission

<table>
<thead>
<tr>
<th>DATE:</th>
<th>TIME:</th>
<th>AREA/UNIT:</th>
</tr>
</thead>
</table>

Admitted from:  
- [ ] Home  
- [ ] E.R.  
- [ ] Clinic  
- [ ] Outside Hospital  

- [ ] Nursing Home  
- [ ] Other:  

In case of emergency, notify:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Phone number(s):</th>
</tr>
</thead>
</table>

<table>
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<th>Name:</th>
<th>Relationship:</th>
<th>Phone number(s):</th>
</tr>
</thead>
</table>

- [ ] Accompanied by:  
  - [ ] No One  
  - [ ] Family/Friend

Allergies:  
- [ ] None known  
- [ ] Correct per PSL  
- [ ] Yes: type/reaction  
- [ ] Latex

**HEALTH PERCEPTION / HEALTH MANAGEMENT**

- Help staff teach you about your health & care,  
- Tell us about you, the patient

- Check all that apply

**Issues that make it hard to learn:**  
- [ ] Hearing  
- [ ] Vision  
- [ ] Memory / Forgetfulness  
- [ ] Feelings (sadness, worry)  
- [ ] Lack of resources (money, help at home)  
- [ ] Pain, comfort  
- [ ] Other:  
- [ ] None

**When teaching me, consider my:**  
- [ ] Usual meal, diet  
- [ ] Finances, money  
- [ ] Faith, religion  
- [ ] Use of treatments such as massage  
- [ ] Or products such as vitamins, herbs  
- [ ] Culture  
- [ ] Other:  
- [ ] None

**Reason for admission/visit:**  
- What have you been doing for this?  
  - [ ] Nothing  
  - [ ] Other:  
- Has it been effective/working/helping you?  
  - [ ] Yes  
  - [ ] No  
  - [ ] Not sure  
  - [ ] Not sure  
  - [ ] Other:  
- What do you expect will be done during your hospital stay?  
  - [ ] Not sure  
  - [ ] Not sure  
  - [ ] Other:

**Patient perception of general health:**  
- [ ] Excellent  
- [ ] Very good  
- [ ] Good  
- [ ] Fair  
- [ ] Poor: (Describe)

**How soon do you expect to go home/leave the hospital?**  
- [ ] Days/week  
- [ ] Doesn't know  
- [ ] NA

**Significant health history (diases/surgeries and management of current diseases):**  
- [ ] None  
- [ ] Unknown  
- [ ] See Admitting H & P per MD/NP/PA

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**ADULT FUNCTIONAL HEALTH PATTERN ASSESSMENT**

2300704  
Rev. 9/09  
HM 2/00  
MEDICAL RECORD  

TAUBMAN GEN MED  
PAGE 01/03
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ADULT FHPA: MEDICATIONS: see Admitting H & P per MD/NP/PA for current medications

- Have you taken any medications in the last 24 hours (including patches and herbal and topical medications)?  □ No  □ Yes
- If yes, What were they?

Substance use:

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>□ Current smoker</th>
<th>□ Former smoker: quit</th>
<th>□ Never smoked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>□ No  □ Yes</td>
<td>□ Type/quantity:</td>
<td>□ Last used:</td>
</tr>
<tr>
<td>Street Drugs/Other</td>
<td>□ No  □ Yes</td>
<td>□ Type/quantity:</td>
<td>□ Last used:</td>
</tr>
</tbody>
</table>

Recent exposure to communicable diseases (such as chicken pox, TB, etc. within last 30 days)? □ yes □ no □ Unknown

Immunization status: up to date?
- Tetanus: □ Yes  □ Date □ No □ Unknown

SEE VACCINE ASSESSMENT

COGNITIVE / PERCEPTUAL (NEUROLOGICAL)

Senses:

<table>
<thead>
<tr>
<th>Hearing</th>
<th>□ no known deficits</th>
<th>□ deficit</th>
<th>□ Compensation: describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>□ no known deficits</td>
<td>□ deficit</td>
<td>□ Compensation: describe</td>
</tr>
<tr>
<td>Speech</td>
<td>□ no known deficits</td>
<td>□ deficit</td>
<td>□ Compensation: describe</td>
</tr>
</tbody>
</table>

LOC
- □ see 24 hour flowsheet
  □ Paresthesia only to deep stimulation - since □ unknown
  □ slow to arouse - since □ unknown
  □ unresponsive - since □ unknown

Cognition - oriented to □ person □ place □ time □ situation
- □ No apparent difficulties □ NA  □ "Long term memory deficit" □ "Unable to respond appropriately"
- □ "Short term memory deficit" □ "Unable to follow commands" □ Able to follow simple commands only

NUTRITION / METABOLIC

Height:  □ see 24 hour flowsheet

Weight: lbs/kg

Diet PTA: □ General □ Low fat/cholesterol □ Carb controlled □ Salt restricted □ Weight loss □ Other:

Recent unintentional weight gain (how much? lbs. over weeks/months)

Diabetes: □ No  □ Yes - 1st dx at age □ Mgmt: □ Diet & activity □ Insulin injections/pump □ Oral agents
- □ Hypo/hyperglycemia (frequency/symptoms/treatment):
- □ Home glucose Monitoring? □ No □ Yes - frequency: ; Usual range: □ uses to adjust Insulin;
- □ Past Diabetes Education? □ No □ Yes □ Unknown
- □ Problems:

If any of the following are marked yes, process RD referral in CareLink within 24 hours of admission:
- □ Yes □ No □ Unknown
- □ Yes □ No □ Unknown
- □ Yes □ No □ Unknown
- □ Yes □ No □ Unknown □ N/A
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### ELIMINATION

<table>
<thead>
<tr>
<th>Urinary History/Pattern:</th>
<th>Bowel History/Pattern:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No problems</td>
<td>□ No problems</td>
</tr>
<tr>
<td>□ Pain</td>
<td>□ Frequency</td>
</tr>
<tr>
<td>□ Blood</td>
<td>□ Urgency</td>
</tr>
<tr>
<td>□ Loss of control/leakage</td>
<td>□ Nocturia</td>
</tr>
<tr>
<td>□ Difficulty starting</td>
<td>□ Ostomy/Tube</td>
</tr>
<tr>
<td>□ Special Management:</td>
<td>□ Other</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

### ACTIVITY / EXERCISE (CARDIOVASCULAR / RESPIRATORY / MUSCULOSKELETAL) - KATZ SCALE

Do you presently have any difficulties with daily activities? □ No □ Yes (Describe): ___________

Management of any activities that interfere with ADLS: ___________

Any Falls within last 6 mos.? □ No □ Yes (Describe): ___________

#### Key for scoring ADL activities:

<table>
<thead>
<tr>
<th>Level 0: full self-care</th>
<th>ADL activities: (* for 1 - 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1: needs equipment or device</td>
<td>Feeding: 0 1 2 3 4</td>
</tr>
<tr>
<td>Level 2: needs assistance or supervision of another person</td>
<td>Bathing: 0 1 2 3 4</td>
</tr>
<tr>
<td>Level 3: needs assistance or supervision of another person &amp; equipment</td>
<td>Tolieting: 0 1 2 3 4</td>
</tr>
<tr>
<td>Level 4: dependent and does not participate</td>
<td>Bed mobility: 0 1 2 3 4</td>
</tr>
</tbody>
</table>

Consult with Physician regarding referral for fuculent functional assessment

### SLEEP / REST

Sleep quantity/quality sufficient for desired/required activities? □ Yes □ No, (Describe): ___________

Pattern of sleep: ___________

Use of aids: □ No □ Yes, (Describe): ___________

### ROLE / RELATIONSHIP

Occupation: ___________

Resources at home (to help patient after discharge):
- Marital status: M S W D Sep How long?
- Household members: ___________
- Living arrangements: □ NA/unknown □ home □ apartment
  □ assisted living □ nursing facility
  Description (e.g. stairs/accessibility): ______________________
  □ no access issues
- Financial concerns: □ No □ Yes
  Anticipated continuing care needs after this visit: □ None □ NA
  □ Home care services □ Extended care facility
  □ equipment/supplies □ IV/Infusion therapy
  □ other: ______________________

### ABUSE/NEGLECT - INTERVIEW PRIVATELY

If unable to ask the following 4 questions, must indicate reason:

1. Are you afraid of anyone close to you? □ No □ Yes - whom?
2. Have you ever been hit, slapped, kicked, pushed, shoved or otherwise physically hurt by your partner or someone close to you? □ No □ Yes - date of last episode?
3. Are you frequently upset, ashamed or embarrassed by someone close to you? □ No □ Yes - whom?
4. Has anyone forced you to have sexual activities? □ No □ Yes - date of last episode?

If yes to any abuse/neglect questions, refer to Abuse Consultation Team or Social Work.

### SEXUALITY / REPRODUCTIVE

- Any sexual issues you want to address during this visit? □ No □ Yes (Describe): ______________________
  Are you sexually active? □ NA □ No □ Yes
  Are you using safe sex practices? □ NA □ No □ Yes (Describe): ______________________
  Last menstrual period: □ Don’t know □ NA
  Pregnant? □ No □ Yes □ Don’t know

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COPING / STRESS / TOLERANCE

1. How do you see yourself managing with what is currently happening to you? □ Don't know □ No issues □ NA □ Other:

2. Coping strategies/support systems: □ self □ family □ friends □ faith □ other: __________________________________________________________________________ □ NA

3. For patient: Do you have any unmet care needs? □ No □ Yes (Describe):

4. For caregiver: Do you feel overwhelmed or frustrated with any aspects of caregiving? □ No □ Yes (Describe):

5. Do you have any current thoughts of suicide? □ No □ Yes (Describe):

6. Have you had any past suicide attempts? □ No □ Yes (Describe):

7. Do you have a history of aggression? □ No □ Yes (Describe):

8. Do you have thoughts or plans to harm someone? □ No □ Yes (Describe):

Information obtained from: □ Patient □ Family □ Medical record □ Interpreter □ Other

<table>
<thead>
<tr>
<th>Initial RN signature:</th>
<th>Date/Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update RN signature:</td>
<td>Date/Time:</td>
</tr>
</tbody>
</table>

FHPA UPDATE
Prior FHPA copy may be used for new admission within 30 days of initial completion.

□ Information current as written (this includes nutrition/functional screening)

□ Changes noted in text & initialed

Signature: __________________________________________________________________________ Date/Time: __________

ADDITIONAL COMMENTS — DATA

__________________________________________________________________________________________________________________________________________________________