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TÜRKİYE ULUSAL AJANSI
TURKISH NATIONAL AGENCY

EMERGENCY SERVICE ADULT PATIENT ANAMNESIS FORM

PATIENT'S IDENTIFICATION AND ADMISSION INFORMATION

Full Name:	Date and Time of Admission: /
National ID Number:	Protocol Number:
Gender: Female ☐ Male ☐	Date of Birth:
Name of Accompanying Person:	Relationship to the Patient:
Arrival at the Hospital: ☐ In arms ☐ Walking ☐ By ambulance ☐ By private vehicle ☐ Other:	

PATIENT'S HEALTH PROBLEMS-COMPLAINTS

COMPLAINT:	
When did the complaint start?	..... Mode of Onset: ☐ Sudden ☐ Gradual
Has the patient experienced a similar complaint before?	☐ No ☐ Yes – When: .....
Has the patient had shortness of breath?	☐ Yes ☐ No
Has the patient had a high fever?	☐ No ☐ Yes .....°C
Has the patient had nausea?	☐ No ☐ Yes – Number of episodes:..... - Color.....
Has the patient had vomiting?	☐ No ☐ Yes – Number of episodes:..... - Color.....
Does the patient have chest pain?	☐ Yes ☐ No
Does the patient have abdominal pain?	☐ Yes ☐ No
Does the patient have a headache?	☐ Yes ☐ No
Are there any additional complaints?	☐ No ☐ Yes
ACCOMPANYING ADDITIONAL COMPLAINTS:	☐ Fever ☐ Shortness of breath ☐ Cough ☐ Cyanosis ☐ Palpitations ☐ Chest pain ☐ Syncope ☐ Fatigue ☐ Memory loss ☐ Seizure ☐ Insomnia ☐ Drowsiness ☐ Dizziness ☐ Loss of appetite ☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Headache ☐ Altered consciousness ☐ Inability to urinate ☐ Skin rash ☐ Fall ☐ Traffic accident ☐ Bleeding ☐ Injury ☐ Fracture / Dislocation

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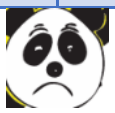
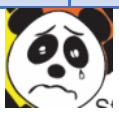
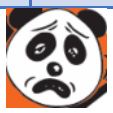
Known allergies: ☐ None ☐ Yes:	Current medications: ☐ None ☐ Yes:
Previous surgeries: ☐ None ☐ Yes:	Chronic medical conditions: ☐ None ☐ Yes:
When did the patient last eat/drink?:	Vaccination status: ☐ Complete ☐ Incomplete – Which ones are missing?:
Habits: ☐ None ☐ Yes –…….	Pregnancy status (for female patients): ☐ Yes ☐ No ☐ Unknown
Occupation: …….	Blood type: …….

VITAL SIGNS OF THE PATIENT

Blood pressure	Heart Rate (Pulse)	Respiratory rate	Body Temperature	SpO2 (%)	AVPU /GCS

Current height and weight: ……. cm / ……. gr

IF THERE IS PAIN, PAIN SEVERITY

NO	MILD		MODERATE		SEVERE		VERY SEVERE		UNBEARABLE	
0	1	2	3	4	5	6	7	8	9	10
										
0	MILD PAIN		MODERATE PAIN				SEVERE PAIN			

TRIAGE LEVEL AND WAITING TIME	Critical	Very urgent	Urgent	Semi urgent	Not urgent
					
	0 minutes	10 minutes	60 minutes	120 minutes	240 minutes

RECOMMENDATIONS AND PLAN:

Details of the Healthcare/ Triage Personnel Taking Anamnesis

Full Name:	
Title:	
Signature / Date:	

İZMİR KÂTİP ÇELEBİ ÜNİVERSİTESİ
ADEM AFAD
MAVİ PENCERE Special Education Association
ISTITUTO DEI SORDI DI TORINO
UNIVERSIDADE CATÓLICA PORTUGUESA
VSL Medicine

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Sample Scenarios / Sign Language Recording

EMERGENCY SERVICE ADULT PATIENT ANAMNESIS FORM	
QUESTIONS – (*HEALTHCARE PROFESSIONAL*) SIGN LANGUAGE	ANSWERS – (PATIENT) SIGN LANGUAGE
Hello, I hope everything is okay. Can I have your ID card?	*(PATIENT GIVES HIS ID CARD) Here you are.*
How did you get to the hospital?	*I came by my own car.*

HEALTH PROBLEMS-COMPLAINTS	
QUESTIONS – (HEALTHCARE PROFESSIONAL)	ANSWERS – (PATIENT)
What is your complaint?	*I have shortness of breath.*
	I have a fever.
	I have nausea and vomiting.
	I have diarrhea.
	I have chest pain.
	I have abdominal pain.
	I have a headache.
When did your complaint start?	*It started an hour ago.*
Have you had a similar complaint before?	*No, I haven't had a similar complaint before.*
Have you experienced nausea or vomiting?	*Yes, I have.*
What color was the vomit?	*It was brown.*
	It was bloody.
Do you have diarrhea?	*Yes, I do.*
What color was your stool?	*It looked normal to me.*

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	I saw blood in it.
Do you have a cough?	*Yes, I do.*
Do you have sputum?	*Yes, I do.*
What color is the sputum?	*It is green.*
Do you have any other complaints?	*No, I have no other complaints.*
Do you have any allergies?	*I don't know*
Are you taking any medication regularly?	*No, I'm not taking any medication.*
Have you had any surgeries?	*No, never.*
Do you have any medical conditions?	*No, none.*
When did you last eat / drink?	*I ate one hour ago.*
Is there any additional information you would like to share regarding your condition?	*No, nothing.*
May we measure your vital signs?	*Yes, of course.*
Do you have pain?	*No, I don't.* *Yes, very much.*
If you were to rate your pain on a scale from 1 to 10, what score would you give?	*I would give it an 8.*

TRIAGE LEVEL **HEALTHCARE PROFESSIONAL DETERMINES THE TRIAGE LEVEL AND INFORMS THE MOTHER**
HEALTHCARE PROFESSIONAL: - *- Your triage level is GREEN.* - *- This is a semi-urgent condition.You may wait in the waiting area for up to two hours until we call you.* *PATIENT:* - *- Thank you. I feel relieved now. I'll be waiting in the waiting area until you call me.*
HEALTHCARE PROFESSIONAL: - *- Unfortunately, your condition is very urgent. The triage level is ORANGE.* - *- We will immediately take you to the emergency room and intervene within 10 minutes.* *PATIENT:* - *Thank you. Please help me.*