

Name: \_\_\_\_\_

# Skills Checklist

## NURSE PRACTITIONER SKILLS CHECKLIST

By accurately filling out this checklist, you will help us match your skills and interests with available assignments. Please place an "X" in the column that best describes your experience level with each skill.

**Level of Proficiency:**  
 1. Can function well independently  
 2. Experience but may need review  
 3. Limited or no experience

Specialties (Please check all that apply)	Yes
ACNP (Acute Care NP)	<input type="checkbox"/>
ANP (Adult NP)	<input type="checkbox"/>
Specialty Programs for Adult NP	<input type="checkbox"/>
Adult Cardiovascular Care NP	<input type="checkbox"/>
Adult Primary Care NP	<input type="checkbox"/>
Adult Critical Care NP	<input type="checkbox"/>
Adult Acute Care NP	<input type="checkbox"/>
ENP (Emergency NP)	<input type="checkbox"/>
FNP (Family Nurse Practitioner)	<input type="checkbox"/>
GNP (Geriatric Nurse Practitioner)	<input type="checkbox"/>
HNP (Holistic Nurse Practitioner)	<input type="checkbox"/>
NNP (Neonatal Nurse Practitioner)	<input type="checkbox"/>
PMHNP (Psychiatric/Mental Health)	<input type="checkbox"/>
APMHNP	<input type="checkbox"/>
(Adult Psychiatric/Mental Health)	
FPMHNP	<input type="checkbox"/>
(Family Psychiatric/Mental Health)	
OHNP (Occupational Health NP)	<input type="checkbox"/>
ONP (Oncology NP)	<input type="checkbox"/>
AONP (Adult Oncology NP)	<input type="checkbox"/>
PONP (Pediatric Oncology NP)	<input type="checkbox"/>
PCNP (Palliative Care NP)	<input type="checkbox"/>
PNP (Pediatric NP)	<input type="checkbox"/>
PCCNP (Pediatric Critical Care NP)	<input type="checkbox"/>
PA/CCNP	<input type="checkbox"/>
(Pediatric Acute/Chronic Care NP)	
WHNP (Women's Health NP)	<input type="checkbox"/>
BC-PCM	<input type="checkbox"/>
(Board Cert. Palliative Care Mgmt.)	
BC-ADM	<input type="checkbox"/>
(Board Cert. Advanced Diabetes Mgmt.)	
ACHPN	<input type="checkbox"/>
(Advanced Cert. Hospice and Palliative)	
Certified Nurse Midwife	<input type="checkbox"/>
OTHER (Please List):	
_____	
_____	

MD Office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobile Medical Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing Home / Long-Term Care Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private Practice (Stand Alone Clinic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rural Health Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urgent Care Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women's Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list):			
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

General	1	2	3
Obtain complete health history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform complete physical exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ordering appropriate lab studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ordering appropriate diagnostic studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpret lab/diagnostic studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Develop differential diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Develop/implement plan for client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arrange referrals/consults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling and patient education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescribe specific therapeutic interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescribe specific medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Authorize/prescribe admission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Authorize/prescribe discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promote "evidence based practice"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Develop illness prevention plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Develop injury prevention plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Develop health promotion plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Principles of Sterile technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunization schedules for all age groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recognition of medical emergencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Age Specific / Age Appropriate Care	1	2	3
Ability to adapt care to incorporate normal growth/development, adapt method/terminology of patient instructions to comprehensive level of patient, and to ensure a safe environment, reflecting specific needs of client.			
Newborn/Neonatal Birth - 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infant (30 Days - 1 year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toddler (1-3 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preschool (3-5 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School Age Children (5-12 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adolescent (12-18 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Young Adults (18-39 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Middle Adults (39-64)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Areas Worked	1	2	3
Acute Care Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulatory Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birthing Center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corporate Worksite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Correctional Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical Access Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Treatment Center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Government Health Agency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Health/Hospice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cardiovascular System	1	2	3
<b>Cardiomyopathy:</b>			
Hypertrophic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dilated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restrictive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Conductive Disorders:</b>			
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Flutter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atrioventricular Block (First, second and third degree)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bundle Branch Block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paroxysmal Supraventricular Tachycardia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premature Beats (PVC, PAC, PJC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ventricular Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ventricular Tachycardia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Congenital Heart Disease:</b>			
Atrial Septal Defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coarctation of the Aorta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patent Ductus Arteriosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tetralogy of Fallot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ventral Septal Defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure (right side)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure (left side)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hypertension:</b>			
Essential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malignant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hypotension:</b>			
Cardiogenic Shock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Septic Shock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthostatic/Postural	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Valvular Disease:</b>			
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Stenosis/Insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tricuspid Stenosis/Insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ischemic Heart Disease:</b>			
Acute MI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stable Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unstable Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prinzmetal's Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Vascular Disease:</b>			
Acute rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arterial Embolism / thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic / Acute Arterial Occlusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PVD (Peripheral Vascular Disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis / Thrombophlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Stenosis / Insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Venous Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acute/subacute bacterial endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acute pericarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Tamponade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pericardial Effusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name: \_\_\_\_\_

# Nurse Practitioner Skills Self-Assessment

## Pulmonary System 1 2 3

- Infections/Disorders:**
- Acute Bronchitis.....
  - Acute Bronchiolitis.....
  - Acute Epiglottitis.....
  - Croup.....
  - Influenza.....
  - Pertussis.....
  - RSV (respiratory syncytial virus).....
  - Tuberculosis.....
- Pneumonia:**
- Bacterial.....
  - Fungal.....
  - HIV related.....
  - Viral.....
- Obstructive Pulmonary Disease:**
- Asthma.....
  - Bronchiectasis.....
  - Chronic Bronchitis.....
  - Emphysema.....
- Pulmonary Circulation:**
- Cor Pulmonale.....
  - Pulmonary Embolism.....
  - Pulmonary Hypertension.....
- Pneumothorax:**
- Primary.....
  - Secondary.....
  - Traumatic.....
  - Tension.....
  - Needle Thoracostomy Procedure.....
- Neoplastic Disease:**
- Bronchogenic Carcinoma.....
  - Carcinoid Tumors.....
  - Metastatic Tumors.....
  - Pulmonary Nodules.....
- Restrictive Pulmonary diseases:**
- Pulmonary Fibrosis.....
  - Pneumoconiosis.....
  - Pulmonary Sarcoidosis.....
- Other Pulmonary Diseases:**
- ARDS (Acute Resp. Distress Syndrome).....
  - RDS (Hyaline Membrane Disease).....
  - Pleural Effusion.....

## Neurological System 1 2 3

- Alzheimer's Disease.....
  - Cerebral Palsy.....
- Diseases of Peripheral Nerves:**
- Bell's Palsy.....
  - Diabetic Peripheral Neuropathy.....
  - Guillain-Barre' Syndrome.....
  - Myasthenia Gravis.....
  - Ramsey Hunt Syndrome.....
- Headaches:**
- Cluster Headache.....
  - Migraine Headache.....
  - Tension Headache.....
- Infectious disorders:**
- Encephalitis.....
  - Bacterial Meningitis.....
  - Viral Meningitis.....

- Movement Disorders:**
- Essential Tremor.....
  - Huntington's Disease.....
  - Parkinson's Disease.....
  - Multiple Sclerosis.....
- Seizure Disorders:**
- Generalized Convulsive disorder.....
  - Generalized Non-Convulsive disorder.....
  - Status Epilepticus.....
- Vascular:**
- Cerebral Aneurysm.....
  - Stroke.....
  - TiA (transient ischemic attack).....

## Musculoskeletal System 1 2 3

- Application/Care of Casts.....
  - Application/Care of Splints.....
- Disorders of the Back/Spine:**
- Ankylosing Spondylitis.....
  - Back sprain/strain.....
  - Cauda Equina Syndrome.....
  - Kyphosis/Scoliosis.....
  - Low Back Pain.....
  - Spinal Stenosis.....
- Infectious Disease:**
- Acute/Chronic Osteomyelitis.....
  - Septic Arthritis.....
- Neoplastic Disease:**
- Bone Cysts/Tumors.....
  - Chondrosarcoma.....
  - Ganglion Cysts.....
  - Ewing's Sarcoma.....
  - Osteosarcoma.....
- Osteoarthritis/Osteoporosis:**
- Fibromyalgia.....
  - Gout/Pseudo Gout.....
  - Juvenile Rheumatoid Arthritis.....
  - Polymyositis.....
- Rheumatoid Conditions:**
- Polymyalgia Rheumatica.....
  - Reiter's Syndrome.....
  - Rheumatoid Arthritis.....
  - Systemic Lupus Erythematosus.....
  - Scleroderma.....
  - Sjogren's Syndrome.....
- Disorders of the Ankle/Foot:**
- Fractures/Dislocations.....
  - Plantar Fasciitis.....
  - Sprain/Strain.....
- Disorders of the Hip:**
- Aseptic Necrosis.....
  - Fractures/Dislocations.....
  - Slipped Capital Femoral Epiphysis.....
- Disorders of the Knee:**
- Bursitis.....
  - Fractures/Dislocations.....
  - Meniscal Injuries.....
  - Osgood-Schlatter Disease.....
  - Sprain/Strain.....
- Disorders of the Shoulder:**
- Fractures/Dislocations.....
  - Rotator Cuff Disorders.....

- Separations.....
  - Sprain/Strain.....
- Disorders of the Forearm/Wrist/Hand:**
- Carpal Tunnel Syndrome.....
  - Fractures/Dislocations.....
  - Gamekeepers Thumb.....
  - Nursemaid's Elbow.....
  - Sprain/Strain.....
- Tenosynovitis:**
- De Quervan's Tenosynovitis.....
  - Elbow Tendonitis.....
  - Epicondylitis.....

## Gastrointestinal System 1 2 3

- Esophagus:**
- Esophagitis.....
  - Motor Disorders.....
  - Mallory-Weiss Tear.....
  - Neoplasms.....
  - Strictures.....
  - Varices.....
- Stomach:**
- Gastroesophageal Reflux Disease.....
  - Gastritis.....
  - Neoplasms.....
  - Peptic Ulcer Disease.....
  - Pyloric Stenosis.....
- Gallbladder:**
- Acute/Chronic Cholecystitis.....
  - Cholelithiasis.....
- Liver:**
- Common Bile Duct Obstruction.....
  - Cirrhosis.....
  - Hepatitis A, B, and C.....
  - Neoplasms.....
- Pancreas:**
- Acute/Chronic Pancreatitis.....
  - Neoplasms.....
- Small Intestine/Colon:**
- Appendicitis.....
  - Constipation.....
- Diverticular Disease:**
- Inflammatory Bowel Syndrome.....
  - Intussusception.....
  - Irritable Bowel Syndrome.....
  - Ischemic Bowel Syndrome.....
  - Neoplasms.....
  - Obstructions.....
  - Toxic Megacolon.....
- Rectum:**
- Anal Fissure.....
  - Anorectal Abscess/Fistula.....
  - Fecal Impaction.....
  - Hemorrhoids.....
  - Neoplasms.....
  - Obstruction.....
- Hernia:**
- Hiatal.....
  - Incisional.....
  - Inguinal.....
  - Umbilical.....
  - Ventral.....

Name: \_\_\_\_\_

# Nurse Practitioner Skills Self-Assessment

## Genitourinary System 1 2 3

<b>Infectious/Inflammatory Conditions:</b>	
Cystitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Epididymitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Orchiditis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Prostatitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pyelonephritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Urethritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Renal Disease:</b>	
Acute/Chronic Renal Failure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Glomerulonephritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Nephrotic Syndrome	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Polycystic Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Volume Depletion/Excess	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Neoplastic Disease:</b>	
Bladder Carcinoma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Prostate Carcinoma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Renal Cell Carcinoma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Testicular Carcinoma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Wilm's Tumor	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Benign Conditions of GU System:</b>	
Benign Prostatic Hyperplasia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cryptorchidism	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Erectile Dysfunction	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hypospadias/Hyperspadias	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Nephro/Urolithiasis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Paraphimosis/Phimosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Testicular Torsion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Urinary Incontinence	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Endocrine System	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Grave's Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hyperthyroidism	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Neoplastic Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Thyroiditis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Thyroid Storm	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hyperparathyroidism	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hypoparathyroidism	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Diseases of the Adrenal Glands:</b>	
Cushing's Syndrome	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Corticoadrenal Insufficiency	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Diseases of the Pituitary Gland:</b>	
Acromegaly/Gigantism	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dwarfism	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pituitary Diabetes Insipidus	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Diabetes Mellitus:</b>	
Type 1 Diabetes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Type 2 Diabetes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Lipid Disorders:</b>	
Hypercholesterolemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hypertriglyceridemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Reproductive System</b>	
<b>Uterus:</b>	
Dysfunctional Uterine Bleeding	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Endometrial Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Endometriosis/Adenomyosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Leiomyoma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Metritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Prolapse	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<b>Cervix:</b>	
Cervical Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cervicitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cervical Dysplasia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Incompetent Cervix	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<b>Ovary:</b>	
Ovarian Cyst	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Middlesmirtz (Ovarian pain)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<b>Vagina/Vulva:</b>	
Cystocele	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Prolapse	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Vaginal Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Vaginitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<b>Complicated /Uncomplicated Pregnancy:</b>	
Abrutio Placenta	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Ectopic Pregnancy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Fetal Distress	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Gestational Diabetes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Gestational Trophoblastic Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
HELLP (premature labor)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Infertility	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Multiple Gestation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Normal (uncomplicated) Pregnancy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Placenta Previa	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Post Partum Hemorrhage	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
PIH (pregnancy induced hypertension)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Premature Rupture of Membranes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Prenatal Diagnosis/Care	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rh Incompatibility	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<b>Menstrual Disorders:</b>	
Amenorrhea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dysmenorrhea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Menopause	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Normal Menses	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Premenstrual Syndrome	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<b>Others:</b>	
Breast Abscess	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Mastitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Fibrocystic Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Contraceptive Methods	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pelvic Inflammatory Disease (PID)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Fibroadenoma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

## Eye, Ear, Nose and Throat 1 2 3

<b>Disorders:</b>	
Blepharitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Blowout Fracture	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cataract	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Chalazion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Conjunctivitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Corneal Abrasion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dacryadenitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Ectropion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Entropion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Foreign Body	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Glaucoma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hordeolum	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hyphema	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Orbital Cellulitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Pytergium	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Retinal Vascular Occlusion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<b>Retinopathy:</b>	
Diabetic Retinopathy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Genetic Retinopathy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hypertensive Retinopathy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<b>Ear Disorders:</b>	
Acute/Chronic Otitis Media	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cerumen Impaction	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Mastoiditis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Meniere's Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Labrynthitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Otitis Externa	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Tinnitus	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Tympanic Membrane Perforation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Vertigo	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<b>Mouth/Throat Disorders:</b>	
Acute Pharyngitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Acute Tonsillitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Canker Sore (aphthous ulcers)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dental Abscesses	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Epiglottitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Gingivitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Laryngitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Oral Candidiasis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Oral Leukoplakia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Peritonsillar Abscess	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Parotitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sialadenitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<b>Nose/Sinus Disorders:</b>	
Allergic Rhinitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Epistaxis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Nasal Polyps	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

## Nutritional Deficiencies 1 2 3

Vitamin A	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Vitamin C	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Vitamin D	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Riboflavin	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Thiamine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

## Hematologic System 1 2 3

<b>Anemias:</b>	
Aplastic Anemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Folate Deficiency	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
G6PD Deficiency	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hemolytic Anemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Iron Deficiency Anemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sickle Cell Anemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Thalassemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Vitamin B12 Deficiency	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Coagulation Disorders:</b>	
Factor VIII Disorders	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Factor IX Disorders	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Factor XI Disorders	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Idiopathic Thrombocytopenic Pupura	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Thrombocytopenia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Thrombic Thrombocytopenic Pupura	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Von Willebrand's Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Name: \_\_\_\_\_

# Nurse Practitioner Skills Self-Assessment

## Hematologic System (Cont.) 1 2 3

<b>Malignancies:</b>			
Acute/Chronic		<input type="checkbox"/>	<input type="checkbox"/>
Lymphocytic Leukemia		<input type="checkbox"/>	<input type="checkbox"/>
Acute/Chronic		<input type="checkbox"/>	<input type="checkbox"/>
Myelogenous Leukemia		<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma		<input type="checkbox"/>	<input type="checkbox"/>
Multiple Myeloma		<input type="checkbox"/>	<input type="checkbox"/>
<b>Infectious Diseases - Bacterial:</b>			
Botulism		<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia		<input type="checkbox"/>	<input type="checkbox"/>
Cholera		<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria		<input type="checkbox"/>	<input type="checkbox"/>
Gonococcal Infections		<input type="checkbox"/>	<input type="checkbox"/>
MRSA (methicillin resistant staph. aureus)		<input type="checkbox"/>	<input type="checkbox"/>
Salmonellosis		<input type="checkbox"/>	<input type="checkbox"/>
Shigellosis		<input type="checkbox"/>	<input type="checkbox"/>
Tetanus		<input type="checkbox"/>	<input type="checkbox"/>
VRE (vancomycin resistant enterococci)		<input type="checkbox"/>	<input type="checkbox"/>
<b>Infectious Diseases - Fungal:</b>			
Candidiasis		<input type="checkbox"/>	<input type="checkbox"/>
Cryptococcosis		<input type="checkbox"/>	<input type="checkbox"/>
Histoplasmosis		<input type="checkbox"/>	<input type="checkbox"/>
Pneumocytosis		<input type="checkbox"/>	<input type="checkbox"/>
<b>Infectious Disease - Mycobacterial:</b>			
Atypical Mycobacterial disease		<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis		<input type="checkbox"/>	<input type="checkbox"/>
<b>Infectious Disease - Parasitic:</b>			
Amebiasis		<input type="checkbox"/>	<input type="checkbox"/>
Hookworms		<input type="checkbox"/>	<input type="checkbox"/>
Malaria		<input type="checkbox"/>	<input type="checkbox"/>
Pinworms		<input type="checkbox"/>	<input type="checkbox"/>
Toxoplasmosis		<input type="checkbox"/>	<input type="checkbox"/>
<b>Infectious Disease - Viral:</b>			
Cytomegalovirus infections		<input type="checkbox"/>	<input type="checkbox"/>
Epstein-Barr infections		<input type="checkbox"/>	<input type="checkbox"/>
Erythema Infectiosum		<input type="checkbox"/>	<input type="checkbox"/>
Herpes Simplex		<input type="checkbox"/>	<input type="checkbox"/>
HIV infection		<input type="checkbox"/>	<input type="checkbox"/>
HPV (human papillomavirus)		<input type="checkbox"/>	<input type="checkbox"/>
Infections		<input type="checkbox"/>	<input type="checkbox"/>
Influenza		<input type="checkbox"/>	<input type="checkbox"/>
Measles		<input type="checkbox"/>	<input type="checkbox"/>
Mumps		<input type="checkbox"/>	<input type="checkbox"/>
Rabies		<input type="checkbox"/>	<input type="checkbox"/>
Roseola		<input type="checkbox"/>	<input type="checkbox"/>
Rubella		<input type="checkbox"/>	<input type="checkbox"/>
Varicella Zoster (chicken pox)		<input type="checkbox"/>	<input type="checkbox"/>
<b>Infectious Disease - Spirochetal:</b>			
Lyme Borreliosis		<input type="checkbox"/>	<input type="checkbox"/>
Lyme Disease		<input type="checkbox"/>	<input type="checkbox"/>
Rocky Mountain Spotted Fever		<input type="checkbox"/>	<input type="checkbox"/>
Syphilis		<input type="checkbox"/>	<input type="checkbox"/>

## Dermatologic System 1 2 3

Debridement		<input type="checkbox"/>	<input type="checkbox"/>
Suturing		<input type="checkbox"/>	<input type="checkbox"/>
Wound Care		<input type="checkbox"/>	<input type="checkbox"/>
Application of Dressings		<input type="checkbox"/>	<input type="checkbox"/>

<b>Bacterial Infections:</b>			
Cellulitis/Vasculitis		<input type="checkbox"/>	<input type="checkbox"/>
Erysipelas		<input type="checkbox"/>	<input type="checkbox"/>
Impetigo		<input type="checkbox"/>	<input type="checkbox"/>
<b>Acneiform Lesions:</b>			
Acne Vulgaris		<input type="checkbox"/>	<input type="checkbox"/>
Folliculitis		<input type="checkbox"/>	<input type="checkbox"/>
Rosacea		<input type="checkbox"/>	<input type="checkbox"/>
<b>Verrucous Lesions:</b>			
Actinic Keratosis		<input type="checkbox"/>	<input type="checkbox"/>
Seborrheic Keratosis		<input type="checkbox"/>	<input type="checkbox"/>
<b>Desquamation:</b>			
Erythema Multiforme		<input type="checkbox"/>	<input type="checkbox"/>
Stevens-Johnson Syndrome		<input type="checkbox"/>	<input type="checkbox"/>
Toxic Epidermal Necrolysis		<input type="checkbox"/>	<input type="checkbox"/>
<b>Eczematous Eruptions:</b>			
Atopic Dermatitis		<input type="checkbox"/>	<input type="checkbox"/>
Contact Dermatitis		<input type="checkbox"/>	<input type="checkbox"/>
Diaper Dermatitis		<input type="checkbox"/>	<input type="checkbox"/>
Perioral Dermatitis		<input type="checkbox"/>	<input type="checkbox"/>
Seborrheic Dermatitis		<input type="checkbox"/>	<input type="checkbox"/>
Stasis Dermatitis		<input type="checkbox"/>	<input type="checkbox"/>
Dyshidrosis		<input type="checkbox"/>	<input type="checkbox"/>
Nummular Eczema		<input type="checkbox"/>	<input type="checkbox"/>
Lichen Simplex Chronicus		<input type="checkbox"/>	<input type="checkbox"/>
<b>Papulosquamous Disease:</b>			
Dermatophyte Infections		<input type="checkbox"/>	<input type="checkbox"/>
<b>Vesicular Bullae:</b>			
Bullous Pemphigoid		<input type="checkbox"/>	<input type="checkbox"/>
<b>Hair and Nails:</b>			
Alopecia Areata		<input type="checkbox"/>	<input type="checkbox"/>
Androgenetic Alopecia		<input type="checkbox"/>	<input type="checkbox"/>
Onychomycosis		<input type="checkbox"/>	<input type="checkbox"/>
Paronychia		<input type="checkbox"/>	<input type="checkbox"/>
<b>Insects/Parasites:</b>			
Lice		<input type="checkbox"/>	<input type="checkbox"/>
Scabies		<input type="checkbox"/>	<input type="checkbox"/>
Spider Bites		<input type="checkbox"/>	<input type="checkbox"/>
<b>Neoplasms:</b>			
Basal Cell Carcinoma		<input type="checkbox"/>	<input type="checkbox"/>
Melanoma		<input type="checkbox"/>	<input type="checkbox"/>
Squamous Cell Carcinoma		<input type="checkbox"/>	<input type="checkbox"/>
<b>Tinea Versicolor:</b>			
Drug Eruptions		<input type="checkbox"/>	<input type="checkbox"/>
Lichen Planus		<input type="checkbox"/>	<input type="checkbox"/>
Pityriasis		<input type="checkbox"/>	<input type="checkbox"/>
Tinea Corporis/Pedis		<input type="checkbox"/>	<input type="checkbox"/>
<b>Viral Disease:</b>			
Condyloma Acuminatum		<input type="checkbox"/>	<input type="checkbox"/>
Exanthems		<input type="checkbox"/>	<input type="checkbox"/>
Fifth Disease (erythema infectiosum)		<input type="checkbox"/>	<input type="checkbox"/>
Herpes Simplex		<input type="checkbox"/>	<input type="checkbox"/>
Molluscum Contagiosum		<input type="checkbox"/>	<input type="checkbox"/>
Varicella Zoster Infections		<input type="checkbox"/>	<input type="checkbox"/>
Verrucae		<input type="checkbox"/>	<input type="checkbox"/>
<b>Other:</b>			
Acanthosis Nigricans		<input type="checkbox"/>	<input type="checkbox"/>
Burn: 1st Degree		<input type="checkbox"/>	<input type="checkbox"/>

Burn: 2nd Degree		<input type="checkbox"/>	<input type="checkbox"/>
Burn: 3rd Degree		<input type="checkbox"/>	<input type="checkbox"/>
Decubitus Ulcers/Stasis Ulcers		<input type="checkbox"/>	<input type="checkbox"/>
Hidradenitis Suppurativa		<input type="checkbox"/>	<input type="checkbox"/>
Lipomas		<input type="checkbox"/>	<input type="checkbox"/>
Melasma		<input type="checkbox"/>	<input type="checkbox"/>
Urticaria		<input type="checkbox"/>	<input type="checkbox"/>
Vitiligo		<input type="checkbox"/>	<input type="checkbox"/>

## Psychiatry/Behavioral Science 1 2 3

<b>Anxiety Disorder:</b>			
Attention Deficit Disorder		<input type="checkbox"/>	<input type="checkbox"/>
Autistic Disorder		<input type="checkbox"/>	<input type="checkbox"/>
Generalized Anxiety Disorder		<input type="checkbox"/>	<input type="checkbox"/>
Panic Disorder		<input type="checkbox"/>	<input type="checkbox"/>
Phobias		<input type="checkbox"/>	<input type="checkbox"/>
PTSD (post traumatic stress disorder)		<input type="checkbox"/>	<input type="checkbox"/>
<b>Eating Disorder:</b>			
Anorexia Nervosa		<input type="checkbox"/>	<input type="checkbox"/>
Bulimia		<input type="checkbox"/>	<input type="checkbox"/>
Obesity		<input type="checkbox"/>	<input type="checkbox"/>
<b>Mood Disorder:</b>			
Adjustment		<input type="checkbox"/>	<input type="checkbox"/>
Depressive		<input type="checkbox"/>	<input type="checkbox"/>
Dysthymic		<input type="checkbox"/>	<input type="checkbox"/>
Bipolar		<input type="checkbox"/>	<input type="checkbox"/>
<b>Personality Disorder:</b>			
Antisocial		<input type="checkbox"/>	<input type="checkbox"/>
Avoidant		<input type="checkbox"/>	<input type="checkbox"/>
Borderline		<input type="checkbox"/>	<input type="checkbox"/>
Histrionic		<input type="checkbox"/>	<input type="checkbox"/>
Narcissistic		<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-Compulsive		<input type="checkbox"/>	<input type="checkbox"/>
Paranoid		<input type="checkbox"/>	<input type="checkbox"/>
Schizoid		<input type="checkbox"/>	<input type="checkbox"/>
Schizotypal		<input type="checkbox"/>	<input type="checkbox"/>
<b>Psychosis:</b>			
Delusional Disorder		<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia		<input type="checkbox"/>	<input type="checkbox"/>
Schizoaffective Disorder		<input type="checkbox"/>	<input type="checkbox"/>
Somatoform Disorder		<input type="checkbox"/>	<input type="checkbox"/>
<b>Substance Use Disorders:</b>			
Alcohol Abuse/Dependence		<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse/Dependence		<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use/Dependence		<input type="checkbox"/>	<input type="checkbox"/>
<b>Other:</b>			
Acute Reaction to Stress		<input type="checkbox"/>	<input type="checkbox"/>
Child/Elder Abuse		<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence		<input type="checkbox"/>	<input type="checkbox"/>
Uncomplicated Bereavement		<input type="checkbox"/>	<input type="checkbox"/>
<b>Electrolyte/Acid Base Disorders 1 2 3</b>			
Hypo/Hypercalcemia		<input type="checkbox"/>	<input type="checkbox"/>
Hypo/Hyperkalemia		<input type="checkbox"/>	<input type="checkbox"/>
Hypo/Hyponatremia		<input type="checkbox"/>	<input type="checkbox"/>
Hypomagnesemia		<input type="checkbox"/>	<input type="checkbox"/>
Metabolic Acidosis		<input type="checkbox"/>	<input type="checkbox"/>
Metabolic Alkalosis		<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Acidosis		<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Alkalosis		<input type="checkbox"/>	<input type="checkbox"/>

Signature: \_\_\_\_\_ Date: \_\_\_\_\_