



Patient Health Assessment

Name: _____ Medical Record # (staff only): _____ Date: _____

DOB: _____ Age: _____ Sex: _____ Previous Provider Name: _____

Marital Status: Married Single Separated/Divorced Widowed

Known Allergies: _____
Immunizations (Date ?): Pneumonia: _____ Tetanus: _____ Hepatitis: _____ Flu: _____ Other: _____
Current Medications and dosages: _____

Social/Cultural History

Are there any specific personal problems or concerns you would like to discuss: _____
Are there any cultural or religious concerns you have related to our delivery of care: _____
Are there any specific household problems you would like to discuss: _____
Are there any financial issues you would like to discuss: _____
Any other social issues you would like discuss: _____
Are there any other topics you would like to discuss: _____

Communication

Language of preference: _____ Are there any vision problems that affect your communication: Y N
Any hearing problems: Y N

Family Medical History: list family members

- Heart Disease, High BP, Asthma, Cancer, Other, High Cholesterol, Lung Disease, Breast Cancer, Thyroid, Glaucoma, Kidney Disease, Diabetes, Alzheimer's, Mental health disorder, Stroke/TIA, Anemia/Blood, Depression/Anxiety

Personal Medical History

Do you or have you ever had any of the following? Please explain
Surgery/Hospitalization, Ulcer/Colitis/Bowel, Sinus Problems, High Cholesterol, Heart Disease, Skin Disease, Bone/Joint Disease, Illegal/Prescription Drug Abuse, Prostate Problems, Kidney/Bladder Problems, Ear Problems, Diabetes, High Blood Pressure, Blood Disease, Circulatory Disease, Abuse, Other mental health disorders, Eye Problems, Thyroid Disease, Respiratory Disease, Neurological Disease, Stroke/TIA, Depression/Anxiety, Alcohol Abuse, GYN Problems

Assessment of Risky Health Behaviors

Do you smoke? Y N # of packs/day _____ Quit since _____ Are you exposed to secondhand smoke? Y N
Do you drink alcohol? Y N # of drinks/week _____
When was the last time you had more than 4-5 drinks in one day? never in past 3 months over three months ago
How often do you exercise? Never Rarely 1 to 3 times/month 1 to 3 times/week 4 to 6 times/week 7 days/week
How would you describe your current weight? Underweight Target weight Overweight
Are you currently trying to lose weight? Y N

Are you sexually active? Y N Do you have any sexual concerns? Y N
 Have you ever been treated for a sexually transmitted disease? Y N
 Do you have any reason to suspect that you have been exposed to HIV or AIDS? Y N
 Do you handle and control the stress in your life? Y N
 Do you sleep well at night? Y N How many hours? _____
 Have you experienced a serious life event recently (death of a family member, divorce, new job, moved, etc.)? Y N
 If yes, please explain _____
 Date of last physical exam: _____ Date of last dental exam: _____ Date of last eye exam: _____

Depression Assessment

In the past month:
 Have you often been bothered by feeling down, depressed, or hopeless? Y N
 Have you often been bothered by little interest or pleasure in doing things? Y N
 Are you generally happy with your life and your current health? Y N

Advance Care Planning

Do you currently have a living will? Y N
 Are you interested in assistance with creating a living will? Y N
 Would you like to receive information about ensuring that your personal wishes are granted if you become seriously ill or injured? Y N

Review of Systems

Please check applicable symptoms below

- Constitutional: Fever Chills Fatigue Night Sweats Weight Gain Weight Loss
- Eye: Blurring Double vision Visual disturbances Eye pain: left or right? Red eye: left or right?
- ENMT: Decreased hearing Trouble swallowing Ear pain: left or right? Nasal congestion Sinus Pain Sore Throat
 Nose bleeds
- Respiratory: SOB Cough Sputum production Coughing up blood Wheezing Sleep apnea
- Cardiovascular: Chest pain Palpitations Syncope Leg swelling
- Gastrointestinal: Nausea Vomiting Diarrhea Constipation Heartburn Abdominal pain Rectal bleeding
- Genitourinary: Pain with urination Urethral discharge Pelvic pain(women) Frequent UTIs Urinary frequency
 Urinary Incontinence Erectile Dysfunction(men)
- Hema/Lymph: Anemia Bruising tendency Bleeding tendency Swollen lymph glands
- Immunologic: Immunocompromised Recurrent fevers
- Musculoskeletal: Back pain Neck pain Joint pain Muscle Pain Joint redness Joint swelling
- Integumentary: Rash Itching Breast lump/mass Breast nipple discharge Breast redness Breast pain
- Psychiatric: Anxiety Depression Bipolar Suicidal Hallucinations Attention disorder Sleeping problems
 Substance Abuse
- Neurologic: Abnormal balance Confusion Dizziness Headache Memory Loss Seizure Ear ringing
 Vertigo