Patient Health Assessment

Name:_____ **Date**:_____

DOB:_____ Age:_____ Sex:_____ Marital Status: □ Married □ Single □ Separated/Divorced □ Widowed

Known Allergies:_____

_____

Immunizations (Date Received): Pneumonia:_____ Tetanus:_____ Hepatitis:_____ Flu:_____ Other:_____

Medications Currently Taking:_____

_____

_____

Social/Cultural History

Are there any specific personal problems or concerns you would like to discuss:_____

_____

Are there any cultural or religious concerns that you have related to our delivery of care:_____

_____

Are there any specific household problems that you would like to discuss:_____

_____

Are there any financial issues that you would like to discuss:_____

_____

Any other social issues that you would like discuss:_____

_____

Communication

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

Any hearing problems: □ Y □ N

If yes, please describe:_____

Family Medical History (Please check if grandparent, parent, sibling or child has a history with these health issues)

□ Heart Disease □ High Cholesterol □ Glaucoma □ Other mental health disorder:_____

□ High BP □ Lung Disease □ Kidney Disease □ Other family medical issues:_____

□ Stroke / TIA □ Asthma □ Breast Cancer _____

□ Diabetes □ Anemia / Blood □ Cancer

□ Thyroid □ Alzheimer's Disease □ Depression/Anxiety

Personal Medical History Do you or have you ever had any of the following? Please explain

□ Surgery/Hospitalization _____ □ Kidney / Bladder Problems _____

□ Eye Problems _____ □ Ulcer / Colitis / Bowel _____

□ Ear Problems _____ □ Thyroid Disease _____

□ Sinus Problems _____ □ Diabetes _____

□ Respiratory Disease _____ □ High Cholesterol _____

□ High Blood Pressure _____ □ Neurological Disease _____

□ Heart Disease _____ □ Blood Disease _____

□ Stroke / TIA _____ □ Skin Disease _____

□ Circulatory Disease _____ □ Depression / Anxiety _____

□ Bone / Joint Disease _____ □ Abuse _____

□ Alcohol Abuse _____ □ Illegal/Prescription Drug Abuse _____

□ Other mental health disorders_____ □ **GYN Problems (for women only)**_____

□ **Prostate Problems (for men only)**_____

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**

How often do you exercise? □ Never □ Rarely □ 1-3 times/month □ 1-3 times/week □ 4-6 times/week □ Everyday

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 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

Any other problems you would like to discuss with the physician: _____

_____

_____

_____