BRIGHAM AND WOMEN'S HOSPITAL
A Teaching Affiliate of Harvard Medical School
75 Francis Street, Boston, Massachusetts 02115

PATIENT IDENTIFICATION AREA

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

Outpatient Self Assessment Form

Date of visit: _____ Age: _____

What is your occupation? _____

Referring MD: _____ PCP: _____

Referring MD Address: _____ PCP Address: _____

Reason for today's visit: _____

Current Medications: 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Non-prescription Medications: 1. _____ 2. _____ 3. _____

Are you currently taking aspirin, Ibuprofen or other blood thinners? _____

Allergies to Medication: ❒ No ❒ Yes If yes, please list: _____

Family history of the following: ❒ Cancer ❒ Diabetes ❒ Heart Disease ❒ Respiratory Disease

Past surgeries and hospitalizations: (Use the reverse side if more space is required.)

Date: _____ Illness/Surgery _____ Hospital/Facility: _____

Please check if you have / had problems with any of the following:

❒ High Blood Pressure	❒ Diabetes	❒ Anemia	❒ Psychiatric disorders _____
❒ Heart disorders	❒ Glaucoma	❒ Immune deficiency	❒ Depression/anxiety
❒ Heart valve	❒ Eye problems	❒ Easy bruising/bleeding	❒ Head injuries: date: _____
❒ Chest Pain (angina)	❒ Thyroid disease	❒ Arthritis	❒ Chronic headache/migraine
❒ Acid Reflux (heartburn)	❒ Asthma	❒ Rashes	❒ Sexually transmitted diseases
❒ Ulcers	❒ Bronchitis	❒ Hearing loss	❒ HIV
❒ Hepatitis	❒ Tuberculosis	❒ Seizures	❒ Cancer: type: _____
❒ Kidney/urinary disease	❒ Emphysema	❒ Stroke	❒ Weight loss (unplanned)

Other: _____

Do you smoke? ❒ No ❒ Yes If no, when did you quit? _____ If yes, how many packs a day? _____ For how many years? _____

Do you drink alcohol? ❒ No ❒ Yes How many drinks per week? _____ Do you use recreational drugs? ❒ No ❒ Yes

Have you had difficulties with the following:

Hygiene	❒ No	❒ Yes	**Walking**	❒ No	❒ Yes
Dressing	❒ No	❒ Yes	**Toileting**	❒ No	❒ Yes

Do you need assistance walking? ❒ No ❒ Yes Do you have a history of falling down? ❒ No ❒ Yes

Do you exercise regularly? ❒ No ❒ Yes If yes, how many times per week? ____ What type of exercise? _____

Have you ever felt unsafe or been afraid of anyone? ❒ No ❒ Yes

Has anyone ever hurt or threatened to hurt you or someone else that you care about? ❒ No ❒ Yes

Do you experience pain as part of your daily life? ❒ No ❒ Yes If yes, on a scale from 1-10, describe this pain: ____
How do you treat this pain? _____

Did you receive a copy of the *"We Care About Your Safety Brochure"*? ❒ No ❒ Yes

Do you understand how to prevent the spread of germs? ❒ No ❒ Yes

I believe the above information is complete to the best of my knowledge:

Date _____ Patient Signature _____ Time _____

Date _____ Reviewed with patient by MD/NP _____ Time _____ CID | | | | | |