Name:

HEALTH ASSESSMENT

Gender: Date of Birth: Age (today):

Treatment Providers (include dental)

Client's report of health information:

EYE PROBLEMS (in past 5 years other than glasses or contacts): ○ Admits ○ Denies

Glaucoma	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Injury	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Visual Change	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Other					

EAR, NOSE, or THROAT PROBLEMS (in past 5 years): ○ Admits ○ Denies

Hay Fever	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Hearing Loss	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Sinusitis	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Other					

TOOTH or GUM PROBLEMS (in past 5 years): ○ Admits ○ Denies

Cavities	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Tooth Pain	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Missing Teeth	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Bleeding Gums	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Other					

HEART PROBLEMS or HIGH BLOOD PRESSURE: ○ Admits ○ Denies

Chest Pain	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Heart Attack	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Heart Surgery	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Heart Trouble	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
High Bld Pressure	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable

Blood Pressure: ○ Reclining ○ Sitting ○ Standing

Taken at (date/time):

Palpitations	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Pulse Rate					
Other					

BREATHING or LUNG PROBLEMS ○ Admits ○ Denies

Asthma	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Coughed Blood	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable

Chronic Cough	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Shortness Breath	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Smoker (any type)	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Emphysema	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Respiration					
Other					

STOMACH, INTESTINAL, or ABDOMINAL PROBLEMS: ○ Admits ○ Denies

Gall Bladder	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Heart Burn	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Stomach Ulcer	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Indigestion	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Intestinal Problems	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Weight Change	☐ Past	☐ Current			☐ No or Not Applicable
Liver Problems	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Rectal Problems	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Rupture / Hernia	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Other					

KIDNEY or BLADDER PROBLEMS (in past 5 years): ○ Admits ○ Denies

Abnrml Urine Test	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Bed-wetting >12y	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Blood in Urine:	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Kidney Stone	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Painful Urination	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Other					

WOMEN ONLY (in past 5 years) ○ Admits ○ Denies ○ Not Applicable

Does client report currently being pregnant?	○ Yes	○ No	
How many times has client been pregnant:	0		
Birth Control?	○ Yes	○ No	
Birth control method:			
Change in Menses?	○ Yes	○ No	
Menopausal?	○ Yes	○ No	
Last Menstrual Period:			
Problems in Pregnancy?	○ Yes	○ No	○ Non-Applicable
Concerns about Breast Problems?	○ Yes	○ No	
Have you had a Mammogram? (Women over 40)	○ Yes	○ No	If YES, When?

GLANDULAR PROBLEMS: ○ Admits ○ Denies

Diabetes	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Obesity	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Thyroid Problems	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable

Other

TUMORS or GROWTHS: ○ Admits ○ Denies

Masses or Growth	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Cancer	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Cysts	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable

Other

BONE, JOINT, or BACK PROBLEMS (in past 5 years): ○ Admits ○ Denies

Arthritis, etc.	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Joint Pain/Swollen	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Recur Back Pain	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable

Other

SKIN PROBLEMS (in past 5 years): ○ Admits ○ Denies

Describe:

NERVOUS SYSTEM/PSYCHIATRIC PROBLEMS: ○ Admits ○ Denies

Agitated/Restless	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Stroke	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Dizziness/Fainting	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Epilepsy/Seizures	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Bad Headaches	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Hallucinations	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Insomnia	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Oversleeping	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Drug/Alcohol Use	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Overdosed	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Sleepwalking	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable
Cutting on Self	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable

Other:

TRAUMA or INJURIES (required ER visit or hospital stay): ○ Admits ○ Denies

Broken Bones	☐ Past	☐ Current	○ Receiving Tx	○ No Tx	☐ No or Not Applicable

Head Injury ☐ Past ☐ Current ○ Receiving Tx ○ No Tx ☐ No or Not Applicable

Anesthesia ☐ Past ☐ Current ☐ No or Not Applicable

List hospitalizations, emergency room visits, surgeries, accidents, fights, et cetera:

Has client been advised to have surgery or any other significant medical intervention? ○ Yes ○ No

If so, describe briefly:

SEXUAL ISSUES/PROBLEMS: ○ Admits ○ Denies

Sexually Active ☐ Past ☐ Current (May choose not to answer) ☐ Declined

Sexual Issues ☐ Past ☐ Current ○ Receiving Tx ○ No Tx ☐ No or Not Applicable

Other:

INFECTIOUS DISEASE (diagnosed or suspected): ○ Admits ○ Denies

Temperature:

Hepatitis (except as a baby) ☐ Past ☐ Current ○ Receiving Tx ○ No Tx ☐ No or Not Applicable
Type:

HIV or AIDS (may choose not to answer) ☐ Declined
☐ Past ☐ Current ○ Receiving Tx ○ No Tx ☐ No or Not Applicable

IV Drug Use ☐ Past ☐ Current ○ Receiving Tx ○ No Tx ☐ No or Not Applicable

TB (Tuberculosis) ☐ Past ☐ Current ○ Receiving Tx ○ No Tx ☐ No or Not Applicable

TB Exposure ☐ Past ☐ Current ○ Receiving Tx ○ No Tx ☐ No or Not Applicable

STD ☐ Past ☐ Current ○ Receiving Tx ○ No Tx ☐ No or Not Applicable

Other

TB CHECKLIST

Sputum-producing cough? ○ Yes ○ No
Coughing up blood? ○ Yes ○ No
Loss of appetite? ○ Yes ○ No
Night sweats? ○ Yes ○ No
Recent fever? ○ Yes ○ No
Received TB meds? ○ Yes ○ No

STD/RISK ASSESSMENT

Sex contact without barrier protection? ○ Yes ○ No
Blood transfusion? ○ Yes ○ No
Yellow jaundice/hepatitis? ○ Yes ○ No
Share needles/works? ○ Yes ○ No
Exchanged sex with money or drugs? ○ Yes ○ No
Been involved in a sexual assault? ○ Yes ○ No

EXERCISE:

Active Exercise ☐ Past ☐ Current ☐ No or Not Applicable

Describe:

Any complaints about energy level or fatigue? ○ Yes ○ No

If so, describe briefly:

Describe pain, as well as any self or medical treatment for it:

ALLERGIES/SENSITIVITIES (medication, food, environmental, et cetera):

○ Yes ○ No ○ Unknown

If yes, explain:

CURRENT MEDICATIONS:

Has client taken any medications in the last two weeks: ○ Yes ○ No

Medications reported by client:

Based on this Health Assessment, the medical staff reviewer recommends:

○ Routine follow up for health issues as indicated.

○ Follow up soon for concerns related to:

- ☐ Eyes (excluding glasses or contacts)
- ☐ Ears, nose, or throat
- ☐ Teeth or gums
- ☐ Heart or blood pressure
- ☐ Breathing
- ☐ Stomach or digestion
- ☐ Kidney or bladder
- ☐ Menstruation or female problems
- ☐ Nutritional status
- ☐ Other:
- ☐ Diabetes
- ☐ Weight
- ☐ Thyroid
- ☐ Tumors or growth
- ☐ Bone, joint, or back
- ☐ Skin conditions
- ☐ Injuries
- ☐ Infectious diseases
- ☐ Pain issues

Follow-Up Instructions: