Person's Name:			**Record #:**		
Organization Name:			**Date of Admission:**		
Person Served Health Care Providers					
Provider	**Name and Credentials**	**Address**	**Tel Number**	**Fax**	**Date of last exam**
Primary Care Physician					
Psychiatrist					
Dentist					
Neurologist					
Ophthalmologist					
Audiologist					
Podiatrist					
OB/GYN					
Pharmacy					
Specialist/Other					

Allergies: ☐ No Known Allergies
Food: Medication: Environmental:

Vital Signs:
Height: Weight: Blood Pressure: BMI:
Respiratory Rate: Pulse: Temperature:

Recent Assessments/Examinations:

Most Recent Bloodwork	**Date**	**Results**	**Physician**
Medication Level			
Blood Chemistry			
Bone Density			
Complete Blood Count			
Hep A			
Hep B			
Hep C			
HIV Assay			
Prostate Screen - PSA			
For OTP only: Liver function profile: SGOT: SGPT: Sickle cell screening:			
Other:			

Person's Name:			**Record #:**
Most Recent Screening	**Date**	**Results**	**Physician**
Last Physical Examination			
TB Screen – PPD			
Chest X Ray			
EKG			
Urinalysis			
Genital Exam / Pap Smear			
Mammogram			
Colonoscopy			
Breathalyzer			

Medical Hospitalizations: ☐ None Reported

Hospital:	Date of Service	Reason (Medical Procedure, Acute Illness, Birth of Child Etc.)

Unresolved Surgical Care Needs ☐ Yes ☐ No
If yes, explain:

If birth of a child, is woman breastfeeding? ☐ Yes ☐ No

Medical History

Cardiovascular Illness*:* ☐ Yes ☐ No
☐ Hypertension ☐ History of heart attack ☐ Coronary Artery Disease ☐ Peripheral Artery Disease
☐ Congestive Heart Failure ☐ Heart Murmur
☐ History of chest pain: Duration: Intensity (1-10): Onset:
Resolution Other:
☐ History of Edema: Location: Type:
Other:

Person's Name:	**Record #:**

Respiratory System: ☐ Yes ☐ No
☐ Chronic Obstructive Pulmonary Disease ☐ Emphysema ☐ Sleep Apnea ☐ Oxygen dependent:
☐ Tuberculosis: ☐ Active ☐ History of / ☐ Treated or ☐ Untreated ☐ C pap machine ☐ Bi-pap machine
☐ Shortness of breath with minimal effort ☐ Inhalant use ☐ Steroid dependent ☐ Asthma

Endrocrine System: ☐ Yes ☐ No
☐ Hyperthyroidism ☐ Hypothyroidism
☐ Obesity ☐ Pre Diabetes ☐ Family History of diabetes ☐ Metabolic Syndrome
☐ Pituitary: ☐ Pineal:
☐ Diabetes ☐ Non-insulin dependent diabetes mellitus ☐ Insulin dependent diabetes mellitus (complete section on Injection Administration)
☐ Type 1 ☐ Type 2 ☐ Diet:
☐ Oral Hypoglycemics ☐ Daily blood sugars:
Able to manage diabetic care on own: ☐ Yes ☐ No ☐ Sometimes ☐ Unknown
☐ Other:

Neurologic Disorder: ☐ Yes ☐ No
☐ Migraines ☐ Headaches ☐ Dizziness
☐ Seizures- Type: Frequency:
☐ Epilepsy ☐ Syncope ☐ Tremors ☐ Delirium Tremens ☐ Decreased sensitivity
☐ History of Head Trauma ☐ History of Stroke/TIA ☐ History of loss of consciousness
☐ Requires prompting under new situations/conditions
☐ Weakness ☐ Paralysis ☐ Somnolent ☐ Distractible
☐ Dementia ☐ Alzheimer's ☐ EEE
☐ Other:

Movement Disorder: ☐ Yes ☐ No
☐ Tardive Dyskenisia ☐ Dystonia ☐ Akathisia ☐ Parkinsonism ☐ Extra Pyramidal Symptoms
☐ Multiple Sclerosis ☐ Cerebral Palsy ☐ Muscular Dystrophy ☐ Other:

Immune System Disorder: ☐ Yes ☐ No
☐ HIV ☐ AIDS ☐ Lupus ☐ Chronic Fatigue Syndrome

Bacterial/Viral Infections: ☐ Yes ☐ No
☐ Sexually Transmitted Infections - (Specify): ☐ MRSA ☐ VRE ☐ Hepatitis: ☐ A ☐ B ☐ C
☐ Lyme Disease ☐ Meningitis

Visual Impairment: ☐ Yes ☐ No
☐ Glaucoma ☐ Cataracts ☐ Blurred Vision ☐ Glasses ☐ Contacts ☐ Itching ☐ Inflammation
☐ Abnormal Pupils ☐ Blind ☐ Legally Blind ☐ Other:
Date of last eye exam:

Auditory Impairment: ☐ Yes ☐ No
☐ Chronic ear infections ☐ Hard of hearing: ☐ *Right* ☐ *Left* ☐ Deaf: ☐ *Right* ☐ *Left*
☐ Hearing Aid(s) ☐ Tinnitus ☐ Vertigo
Date of last hearing exam:
☐ Other:

Digestive/Urinary Conditions: ☐ **Yes** ☐ **No**
☐ **Diarrhea** ☐ **Constipation** ☐ **Incontinence:** ☐ **Fecal** ☐ **Urinary** ☐ **Colitis** ☐ **Crohn's Disease**
☐ **Urinary Infection** ☐ **Prostate Disorder** ☐ **Eating Disorders:** ☐ **Anorexia** ☐ **Bulimia** ☐ **Compulsive Eating**

Person's Name:	**Record #:**

Dental Conditions: ☐ Yes ☐ No
☐ Own teeth, condition:
☐ No Teeth/Missing Teeth
☐ Dentures: ☐ Upper ☐ Full ☐ Partial: fit:
☐ Lower ☐ Full ☐ Partial: fit:
Oral Mucosa: ☐ Moist ☐ Dry ☐ Lesions ☐ Other:

Reproductive Health:
Sexually Active ☐ Yes ☐ No
Pregnant ☐ Yes ☐ No ☐ NA
Birth control method in use: ☐ Yes ☐ No Type:
Sex education needed: ☐ Yes ☐ No

Advanced Directives in place: ☐ Health Care Proxy DNR/Comfort Care Orders
☐ Other Advanced Directives:

Pain Assessment Screening: On a scale of Zero to Five, please rate your level of pain today:

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
No Pain	Mild Pain	Moderate Pain	Severe Pain	Very Severe Pain	Worst Possible Pain

Does pain currently interfere with your daily activities? ☐ Yes ☐ No
If yes how much?: ☐ Some of the time ☐ Most of the Time ☐ All of the Time

Ambulation:
☐ Independent ☐ Steady ☐ Gait disturbance ☐ History of falls ☐ Requires assist/supervision
☐ Adaptive equipment: Specify
☐ Other:

Dietary: ☐ Within Normal Limits
☐ Overweight ☐ Underweight ☐ Recent Weight Loss/Gain:
☐ Swallowing/Feeding Difficulties ☐ Special diet:

Diseases of the Liver: ☐ **None Reported**
☐ **Acute fatty liver** ☐ **Cirrhosis**

Dermatologic Conditions: ☐ **None Reported**
☐ **Acne** ☐ **Eczema** ☐ **Seborrhea** ☐ **Psoriasis** ☐ **Evidence of needle use**
☐ **Other**

Cancer:
Have you ever been diagnosed with Cancer? ☐ **Yes** ☐ **No**
If yes, what type of cancer: **Treatments received:**
Are you currently in remission: ☐ **Yes** ☐ **No, if yes, for how long:** **Years /** **Months**

Person's Name:	**Record #:**

Bone and Joint Conditions: ☐ None Reported
☐ Arthritis ☐ Osteoporosis ☐ Fibromyalgia
Have these conditions led to: ☐ Decreased Mobility ☐ Uses Wheelchair ☐ Uses other Assistive Devices

For Opiate Treatment Programs:

- Attach completed Physical Examination by a qualified health professional including:
  - Physician's overall impression of the client
  - Justification that approved opioid/narcotic being dispensed is not contraindicated with the client's other medications reported
  - Results of Microscopic urinalysis including analysis of glucose and protein

Diagnosis: ☐ DSM Codes (or successor) ☐ ICD Codes (or successor)

Check Primary	Axis	Code	Narrative Description
☐	Axis I		
☐			
☐			
☐	Axis II		
☐			
☐	Axis III		
☐	Axis IV		
☐	Axis V	Current GAF:	Highest GAF in Past Year (if known):

Comments, Recommendations or Referrals by Medical Reviewer: ☐ **No Referral Needed**

Check Referral(s) Needed and Specify Action(s)

☐ Primary Care Physician:

☐ Healthcare Agency:

☐ Specialty Care:

☐ Other - specify:

Recommendations shared with the Person Served?
☐ No ☐ Yes If Yes, the Person's Served Response:

If No, how will recommendations be shared with the Person Served?:

Medical Reviewer - Print Name/Credential:	**Date:**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Medical Reviewer Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**

Date of Service	Provider Number	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code