|  |  |  |
| --- | --- | --- |
| Person’s Name (First MI Last): | Record #: | Date of Admission: |
| Organization/Program Name: | DOB: | **Gender:**  Male  Female  Transgender |

|  |
| --- |
| **Vital Signs:**  Height:       Weight:       Blood Pressure:       BMI:  Respiratory Rate:       Pulse:       Temperature: |
| **Allergies:** No Known Allergies  Medication Allergies and Medication Sensitivities (including OTC, herbal):  Food:       Environmental: |

**Recent Assessments/Examinations:**

|  |  |  |  |
| --- | --- | --- | --- |
| *Most Recent Bloodwork* | Date | Results | Physician |
| Medication Level |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Blood Chemistry |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Fasting Blood Sugar (Hb-A1C) |  |  |  |

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| --- | --- | --- | --- |
| Bone Density |  |  |  |

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| --- | --- | --- | --- |
| Complete Blood Count with Differential |  |  |  |

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| --- | --- | --- | --- |
| Lipid Panel/Cholesterol Level |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Thyroid Level |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Hep A |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Hep B |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Hep C |  |  |  |

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| --- | --- | --- | --- |
| STD Testing |  |  |  |

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| --- | --- | --- | --- |
| HIV Assay |  |  |  |

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| --- | --- | --- | --- |
| Prostate Screen - PSA |  |  |  |

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| --- | --- | --- | --- |
| For OTP only-Liver function profile: |  |  |  |
| SGOT: |  |  |  |
| SGPT: |  |  |  |
| Sickle cell screening: |  |  |  |
| Other: |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Most Recent Screening | Date | Results | Physician |

|  |  |  |  |
| --- | --- | --- | --- |
| Last Physical Examination |  |  |  |

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| TB Screen – PPD |  |  |  |

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| --- | --- | --- | --- |
| Chest X Ray |  |  |  |

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| --- | --- | --- | --- |
| EKG |  |  |  |

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| --- | --- | --- | --- |
| Urinalysis/Routine and Microscopics Drug Screen Etc. |  |  |  |

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| --- | --- | --- | --- |
| Genital Exam / Pap Smear/ Pregnancy Test |  |  |  |

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| --- | --- |
| **Person’s Name:** | **Record #:** |

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| Mammogram |  |  |  |

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| --- | --- | --- | --- |
| Colonoscopy |  |  |  |

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| --- | --- | --- | --- |
| Breathalyzer |  |  |  |

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| --- | --- | --- | --- |
| Others As Indicated: |  |  |  |

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| --- | --- | --- |
| Medical Hospitalizations:  None Reported | | |
| Hospital: | Date of Service | Reason (Medical Procedure, Acute Illness, Birth of Child Etc.) |
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| **Unresolved Surgical Care Needs**  Yes  No  **If yes, explain:** | | |
| Does the person use complimentary health approaches (e.g. natural products, mind-body practices, yoga)?  Yes  No If yes, please describe:  Does the person wish to consider using complimentary health approaches and want help finding a provider?  Yes  No  NA If yes, please describe: | | |

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| --- |
| **Medical History** |
| **Cardiovascular Illness*:*** Yes  No  Hypertension  History of heart attack  Coronary Artery Disease   Peripheral Artery Disease  Congestive Heart Failure  Heart Murmur  CVA (Stroke)  Chest pain: Duration:       Average Intensity (1-10):       Frequency:  Edema: Location:        Non-Pitting Pitting: 1  2 3  4  Other: |

|  |
| --- |
| **Respiratory System**:  Yes  No  Chronic Obstructive Pulmonary Disease  Emphysema  Asthma  Sleep Apnea  Tuberculosis:  Active  History of /  Treated or  Untreated  Oxygen dependent: **Yes**  **No**  C pap machine  Bi-pap machine  Shortness of breath at rest  Shortness of breath minimal effort |

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| --- | --- |
| **Person’s Name:** | **Record #:** |

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

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| --- |
| **Neurological 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  Weakness  Paralysis  Somnolent  Distractible  Dementia  Alzheimer’s  Eastern Equine Encephalitis (EEE)  Requires prompting under new situations/conditions  Other: |

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| --- |
| **Movement Disorder:** ⁭  Yes  No  Tardive Dyskinesia  Dystonia  Akathisia  Parkinsonism  E**xtra Pyramidal Symptoms**  Multiple Sclerosis  Cerebral Palsy  Muscular Dystrophy  Other: |

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| --- |
| **Immune System Disorder:**  Yes  No  HIV  AIDS  Lupus  Chronic Fatigue Syndrome |

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

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| --- |
| **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: |

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| --- | --- |
| **Person’s Name:** | **Record #:** |

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| --- |
| **Digestive/Urinary Conditions:**  Yes  No  Incontinence:  Fecal  Urinary:  Stress Incontinence  Overflow Incontinence  Diarrhea  Constipation  Urinary Infection  Prostate Disorder  Colitis  Crohn’s Disease  Ostomy  Nausea  Vomiting |

|  |
| --- |
| **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  If pregnant, include information on pre-natal care:  Is Woman breastfeeding?  Yes  No  Birth control method in use:  Yes  No Type:  Sex education needed:  Yes  No |

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| --- |
| **Advanced Directives in place:**  Health Care Proxy  DNR/Comfort Care Orders  Other Advanced Directives: |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Pain Assessment Screening:** On a scale of Zero to Ten, please rate your level of pain today: | | | | | | | | | | |
| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| No Pain |  | Mild Pain |  |  | Moderate Pain |  |  | 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 | | | | | | | | | | |

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

|  |
| --- |
| **Dietary/Nutrition**:  Appropriate BMI  Overweight/Obese  Underweight  Recent Weight Loss/Gain:  Swallowing/Feeding Difficulties  Special diet/Fluid restriction: |

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

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

|  |  |
| --- | --- |
| **Person’s Name:** | **Record #:** |

|  |
| --- |
| **Cancer:**  Yes  No  If yes, what type of cancer:       Treatments received:  Currently in remission:  Yes  No, if yes, for how long:       Years /       Months |

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

|  |
| --- |
| **Comments:** |

**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

|  |
| --- |
| **Comments, Recommendations or Referrals by Medical Reviewer:**  **No Referral Needed** |
| **Check Referral(s) Needed and Specify Action(s)** |
| Primary Healthcare Provider: |

|  |
| --- |
| 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?: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Person’s Signature** (Optional, if clinically appropriate) | **Date:** | **Parent/Guardian Signature** (If appropriate): | **Date:** |
| **Clinician/Provider - Print Name/Credential:** | **Date:** | **Supervisor - Print Name/Credential** (if needed): | **Date:** |
| **Clinician/Provider Signature:** | **Date:** | **Supervisor Signature** (if needed): | **Date:** |
| **Psychiatrist/MD/DO** (If required): | **Date:** |  | |