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

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| **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:**

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

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| Blood Chemistry |       |       |       |

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| 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 |       |       |       |

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| Thyroid Level |       |       |       |

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| Hep A |       |       |       |

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| Hep B |       |       |       |

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| 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: |       |       |       |

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| Most Recent Screening | Date | Results | Physician |

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| 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.) |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| **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:       |

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| **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 [ ]  NoAble 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:       |

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| **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 |

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| **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:       |

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| **Reproductive Health:**Sexually Active [ ]  Yes [ ]  NoPregnant [ ]  Yes [ ]  No [ ]  NA If pregnant, include information on pre-natal care:      Is Woman breastfeeding? [ ]  Yes [ ]  NoBirth 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:       |

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

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

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

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

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

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

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| **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

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

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| [ ]  Healthcare Agency:        |

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| [ ]  Specialty Care:        |

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| [ ]  Other - specify:        |

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| Recommendations shared with the Person Served? [ ]  No [ ]  Yes If Yes, the Person’s Served Response:       |

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

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| **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:** |  |