

Patient/Member Name \_\_\_\_\_ Age \_\_\_\_\_ ID# \_\_\_\_\_

Please indicate if you/the patient has/had any of the following by checking the Past or Current box. Also, enter when the condition started. Otherwise, check the None box  for each health item listed:

	Past	Current	None	Date Began/ Onset
Asthma/COPD/Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding(hemophilia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood in Stool/Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Caffeine Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chicken Pox/Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colitis/Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Body Movement/Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ears: Infections/Buzzing/Ringing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hard of Hearing/Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes/Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gall Bladder/ Stomach / GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis (A, B, C, D, E)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure/Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexually Trans.Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Talking/Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	Past	Current	None	Date Began/ Onset
Teeth/Gums/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco Use & Amount:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tonsilitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weight: Gain/Loss/Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain: "Past" = within the last 7 days				
Back/Chest/Neck/Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Legs/Feet/Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arms/Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Severe Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family History of:				
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension/High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lives in a place with bedbugs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Explain all areas checked "Current": \_\_\_\_\_

\_\_\_\_\_

Please answer all of the following:

Do you have allergies?  No  Yes List all: \_\_\_\_\_

Did you receive childhood immunizations?  No  Yes If No, list what was received, if any: \_\_\_\_\_

List dates, types, and hospitals for all hospitalizations/surgeries: \_\_\_\_\_

Date of last medical doctor's examination/visit: \_\_\_\_\_

Dr. Name: \_\_\_\_\_ Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Now under a doctor's care for pain?  Yes  No If Yes, Dr. Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

What medications have you taken in the past? \_\_\_\_\_

What medications do you take now? \_\_\_\_\_

\_\_\_\_\_ Prescribing Physician: \_\_\_\_\_

1) Within the past 21 days, have you been to or been in contact with anyone who has traveled to the countries of Guinea, Sierra Leone, Liberia, Nigeria, or Sengal?  Yes  No

2) If Yes, do you now have any of these symptoms?  Fever of 101.5° or higher  Vomiting  Severe Headache  Stomach Pain  Muscle Pain  Diarrhea  Unexplained Bleeding

**Staff Only: If Yes to 1) AND any of the symptoms are present, promptly segregate the individual and contact the supervisor.**

Please check all that apply to you:

Multiple partners:  No  Yes Sex without condoms:  No  Yes Long-term dialysis before 1992:  No  Yes

Shared drug instruments:  No  Yes Homosexual/bisexual partners:  No  Yes

Clotting factor concentrates before 1987:  No  Yes Blood transfusion or organ transplant before 7/92:  No  Yes

Body piercings or tattoos:  No  Yes Mother may have had Hepatitis C when patient was born:  No  Yes

Born before 1967 and served in military:  Yes  No

**Staff Only: Any "Yes" response indicates the need for: 1) referral for testing if not done within the last 6 months, and 2) the referral and the risk/behavior(s) to appear in the treatment plan.**

Date of last HIV antibody test: \_\_\_\_\_  None

Are you using birth control?  No  Yes Type: \_\_\_\_\_

OB/GYN (Female Only)

Last GYN Exam: \_\_\_\_\_ Number of Pregnancies: \_\_\_\_\_ Due date if now pregnant: \_\_\_\_\_

Number of Miscarriages: \_\_\_\_\_ Number of Stillbirths: \_\_\_\_\_ Number of Abortions: \_\_\_\_\_ Number of Live Births: \_\_\_\_\_

Date of Last Menstrual Period: \_\_\_\_\_ Duration and Frequency: \_\_\_\_\_ Are you breastfeeding now?  Yes  No

What is your weight \_\_\_\_\_ pounds?      What is your height \_\_\_\_\_?

Please circle the number next to the sentence that applies to you:

1	I am on a special diet like: Vegetarian, Kosher, Muslim, Diabetic, low salt, low fat, etc.,
3	I have diabetes.
3	I have had weight loss surgery.
2	I have kidney disease.
1	I have heart disease.
1	I have high blood pressure.
1	I have a lactose intolerance.
1	I am allergic to any of these: soy, citrus, nuts, seafood/fish, eggs, mushrooms, strawberries, wheat/gluten.
1	I am allergic to other food not listed above.
2	I have lost more than 10 pounds in the last month without trying.
2	I have been vomiting or have had diarrhea or constipation for more than 3 days, in the last 7 days.
3	I have a problem chewing and/or swallowing food.
3	I have a history of an eating disorder (vomiting/using laxatives on purpose after eating, or skipping meals/eating very little most of the time).
3	I take a blood thinner (Coumadin/Warfarin).
3	I am pregnant or breast feeding.
	∴ ∴ ∴ ∴ ∴ ∴ <b>FOR STAFF USE ONLY</b> ∴ ∴ ∴ ∴ ∴ ∴
	Wt. _____ lbs. X 703 = _____ ÷ (Ht. in inches _____) X (Ht. in inches) _____ = BMI _____
3	BMI < 18.5 / appears emaciated
2	BMI > 40 / appears obese
	<b>TOTAL NUTRITION SCREEN SCORE</b>
	<b>Moderate/high nutritional risk due to a score of ≥ 7 necessitates 1) a referral to a Nutritionist / Dietician or PCP, and 2) the referral to appear in the treatment plan.</b>

TUBERCULOSIS HEALTH HISTORY	YES	NO	UNKNOWN
1. Have you coughed up blood within the last 3 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you had ongoing appetite and weight loss of 10 lbs. or more within the last 2 months without trying?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you had ongoing sweating while sleeping that leaves bed linens and clothes wet?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you had a cough for more than 3 weeks (especially, not responding to treatment)?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you had a fever more than 100° F that lasted longer than 2 weeks within the last 3 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you had close contact within the last 6 weeks with someone that had/has TB?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you had a positive PPD in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had a severe PPD reaction in the past (blister, ulcerations, anaphylactic shock)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have eczema?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Have you had a major viral infection or a live virus vaccine (like for mumps, measles, or German measles) in the past 30 days?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Have you completed TB treatment (minimum 6 months) in the past?	<input type="checkbox"/>	<input type="checkbox"/>	

**FOR STAFF COMPLETION ONLY PPD (TB) Testing Criteria Check appropriate box below:**

Yes to any questions 1 - 6 = PPD skin test referral

Yes to any questions 1 - 6 AND 7 = Chest x-ray referral

Yes to any questions 8, 9, 10, 11 = No PPD skin test/Chest x-ray

Yes to any questions 1-6 AND yes to any questions 8-11 = Chest x-ray referral

Absence of Yes responses directly above in Testing Criteria = No PPD skin test/Chest x-ray

\_\_\_\_\_  
Signature of Patient/Person Completing Form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Person Signature with Credentials

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature with Credentials

\_\_\_\_\_  
Date