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:

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

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

Explain all areas checked "Current":

Please answer all of the following:

Do you have allergies? ☐ No ☐ Yes List all: _____

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

_____

Have you seen a medical doctor/provider in the last 3 months? ☐ No ☐ Yes If yes, date: _____

Dr. Name: _____ Address: _____ Telephone #: _____

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

Address: _____ Telephone #: _____

What medications have you taken in the past?_____

_____

What medications do you take now? _____

_____ Who prescribed? _____

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? ☐ No ☐ Yes

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) <u>AND</u> any of the symptoms are present, promptly segregate the individual and contact the supervisor.

Please check **No** or **Yes**:

Sex with someone with a STD or HIV: ☐No ☐Yes Multiple partners: ☐No ☐Yes Homosexual/bisexual partners: ☐No ☐Yes

In last 90 days have you or a sex partner had a sore on the penis/vagina: ☐No ☐Yes Sex without condoms: ☐No ☐Yes

MEN: Discharge from penis: ☐No ☐Yes

WOMEN: Pain during vaginal sex: ☐No ☐Yes Vaginal discharge different from your normal: ☐No ☐Yes

:

Long-term dialysis before 1992: ☐No ☐Yes Shared drug instruments: ☐No ☐Yes Body piercings or tattoos: ☐No ☐Yes

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

Your mother may have had Hepatitis C when you were born: ☐No ☐Yes Born before 1967 and served in military: ☐Yes ☐No

You had blood-to-blood contact where you had questions about your HIV status, that is, dental work, hemophelia treatment, blood transfusion: ☐No ☐Yes

Staff Only: Any "Yes" response indicates the need for: 1) documented referral for Hepatitis/STD/HIV 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: _____

Female Only - Last GYN Exam: _____ Number of Pregnancies: _____ _____

Number of Miscarriages: _____ Number of Stillbirths: _____ Number of Abortions: ____ Number of Live Births: ____

Have you missed your last 2 menstrual periods: ☐No ☐Yes Duration and Frequency: _____

Due date if now pregnant: _____ If pregnant, getting pre-natal care: ☐No ☐Yes Breastfeeding now: ☐Yes ☐No

My current weight is _____ pounds. My usual weight is _____ pounds.I am _____ feet _____ inches tall.

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

1	I follow a special diet: __ Vegetarian Low Salt__ Low Fat/Low Cholesterol __ Other. Please specify _____.
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 an intolerance to __ Lactose __ Gluten __ Other. Please specify _____
1	I am allergic to __ Soy __ Citrus __ Nuts __ Seafood/fish __ Eggs __ Mushrooms __Berries __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 month.
3	I have a problem with my teeth, and/or 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.
	∴ ∴ ∴ ∴ ∴ ∴ **FOR STAFF USE ONLY** ∴ ∴ ∴ ∴ ∴ ∴
	Wt._____lbs. X 703 = _____ (Ht. in inches_____) X (Ht. in inches) _____ = BMI_____
3	BMI < 18.5 / appears emaciated
2	BMI > 40 / appears obese
	TOTAL NUTRITION SCREEN SCORE
	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.

TUBERCULOSIS HEALTH HISTORY	YES	NO	UNKNOWN
1. Have you coughed up blood within the last 3 weeks?	☐	☐	
2. Have you had ongoing appetite and weight loss of 10 lbs. or more within the last 2 months without trying?	☐	☐	
3. Have you had ongoing sweating while sleeping that leaves bed linens and clothes wet?	☐	☐	
4. Have you had a cough for more than 3 weeks (especially, not getting better with treatment)?	☐	☐	
5. Have you had a fever more than 100° F that lasted longer than 2 weeks within the last 3 weeks?	☐	☐	
6. Have you had close contact within the last 6 weeks with someone that had/has TB?	☐	☐	
7. Have you had a positive TB test in the past?	☐	☐	☐
8. Have you had a severe TB test reaction in the past (blister, ulcerations, anaphylactic shock)?	☐	☐	☐
9. Do you have eczema?	☐	☐	
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?	☐	☐	
11. Have you completed TB treatment (minimum 6 months) in the past?	☐	☐	

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

Yes to any questions 1 - 6 = TB skin test referral which is included in the treatment plan. ☐
Yes to any questions 1 - 6 AND 7 = Chest x-ray referral which is included in the treatment plan ☐
Yes to any questions 8, 9, 10, 11 = No TB skin test/Chest x-ray ☐
Yes to any questions 1-6 AND yes to any questions 8-11 = Chest x-ray referral which is included in the treatment plan ☐
Absence of Yes responses directly above in Testing Criteria = No TB skin test/Chest x-ray ☐

Signature of Patient/Person Completing Form _____ Date _____

Staff Person Signature with Credentials _____ Date _____

Physician Signature with Credentials _____ Date _____