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PATIENT ASSESSMENT FORM

GENERAL INFORMATION

1) **Full Name? _____**
2) **Date of Birth _____**
3) **Height?** (in inches, 5 feet = 60 inches, 6 feet = 72 inches) _____
4) **Weight? (in pounds) _____**
5) **Dominant hand?**
   a. Left
   b. Right
6) **Employment Status?** **Occupation/Job Title _____**
   a. Employed
   b. Unemployed
   c. Student
   d. Retired
7) **Who is your Primary Care Physician (PCP)? _____**
8) **Please provide the name of your Emergency Contact: _____**

11a) Please provide the relationship of your Emergency Contact: _____

11b) Please provide the phone number for your Emergency Contact: _____

9) **Are you 65 years of age older?**
a. Yes
b. No

9a) If yes, do you have a history of falls?

a. Yes
b. No

9a1) If yes, how many falls in the last 12 months? _____

9a2) Injury sustained from falls?

a. Yes
b. No

9**a3) Balance Problems?**

a. Yes
b. No

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YOUR PERSONAL MEDICAL HISTORY

1) **Have you ever been treated for any of the following medical conditions? (Please check all that apply)**

	Yes	No		Yes	No		Yes	No
Alzheimer's			Heart Palpitations			Osteoarthritis		
Anemia			Hepatitis A			Osteomyelitis		
Anxiety			Hepatitis B			Osteopenia		
Asthma			Hepatitis C			Osteoporosis		
Bladder Control Problems			High Blood Pressure			Parkinson's Disease		
Bladder Infections			High Cholesterol			Pneumonia		
Bleeding Tendency			History of Fractures			Psoriasis		
Blood Clot (DVT)			HIV			Pulmonary Embolism		
Cancer			Hyperthyroidism			Rheumatoid Arthritis		
Coagulation Disorder			Hypothyroidism			Sciatica		
COPD			Kidney Disease			Seizures		
Depression			Kidney Stones			Shingles		
Diabetes Type 1			Liver Disease			Sleep Apnea		
Diabetes Type 2			Lung Disease			Sleep Disorder		
Diverticulitis			Lupus			Steroid Use		
Emphysema			Erythematosus			Stomach Ulcers		
Esophageal Reflux (GERD)			Lyme Disease			Stroke/TIA		
Glaucoma			Malignant Hyperthermia			Thyroid Disease		
Gout			Migraine Headache			Tuberculosis		
Heart Attack (Myocardial Infraction)			Multiple Sclerosis			Varicose Veins		

Other: _____

PAST SURGICAL/HOSPITALIZATION HISTORY

1) **Do you have any previous surgeries or hospitalizations?**
   a. Yes
   b. No

   1a) Please list all prior surgeries, the hospital/location and reason to the best of your ability (only month/year necessary)

Year	Hospital/Location	Reason

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2) **Do you have any implants (pins, rods, screws, etc.)?**
   a. Yes
   b. No

   2b) If yes, where are they? _____

3) **Have you ever had any problems with anesthesia?**
   a. Yes
   b. No

Social History

1) **Marital Status?**
   c. Married
   d. Single
   e. Widowed
   f. Divorced
   g. Separated
   h. Significant Other

2) **Smoking?**
   a. Current every day smoker
   b. Current some day smoker
   c. Former smoker
   d. Never smoker
   e. Unknown if ever smoked
   f. Heavy tobacco smoker
   g. Light tobacco smoker

   2a) If current smoker, how many packs per day? _____

   2c) If former smoker, when did you quit smoking? _____

3) **Alcohol?**
   a. Never drink
   b. Occasional drinker
   c. Daily 1-2 drinks
   d. Daily 2-5 drinks
   e. Daily heavy use
   f. Occasional heavy use

4) **Are you taking any unprescribed drugs, including recreational drugs?**
    a. Yes
    b. No

    4a) If yes, please specify: _____

5) **Exercise?**
    a. Exercises regularly
    b. Does not exercise regularly

6) **Are you currently residing at a Nursing/Rehab facility?**
    a. Yes
    b. No

Obstetrical History (Females Only)

1) Are you currently pregnant?
    a. Yes
    b. No

2) Number of children: ____

3) Number of pregnancies: ___

4) Number of deliveries: ____

*******PLEASE CONTINUE ONTO NEXT PAGE*******

Your Family Medical History (Parent and Siblings):

(F=Father; M=Mother; S=Sibling; C=Child/Children; O=Other)

	F	M	S	C	O		F	M	S	C	O		F	M	S	C	O
Alzheimer's						Heart Palpitations						Osteoarthritis					
Anemia						Hepatitis A						Osteomyelitis					
Anxiety						Hepatitis B						Osteopenia					
Asthma						Hepatitis C						Osteoporosis					
Bladder Control Problems						High Blood Pressure						Parkinson's Disease					
Bladder Infections						High Cholesterol						Pneumonia					
Bleeding Tendency						History of Fractures						Psoriasis					
Blood Clot (DVT)						HIV						Pulmonary Embolism					
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Coagulation Disorder						Hypothyroidism						Sciatica					
COPD						Kidney Disease						Seizures					
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Diabetes Type 1						Liver Disease						Sleep Apnea					
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Diverticulitis						Lupus						Steroid Use					
Emphysema						Erythematosus						Stomach Ulcers					
Esophageal Reflux (GERD)						Lyme Disease						Stroke/TIA					
Glaucoma						Malignant Hyperthermia						Thyroid Disease					
Gout						Migraine Headache						Tuberculosis					
Heart Attack (Myocardial Infraction)						Multiple Sclerosis						Varicose Veins					

1) **Are you adopted?**
   a. Yes
   b. No

4) **Allergies?**

Allergy	No	Yes	Allergic to:	Reaction:
Latex				
Metal				
Medication				
Other				

MEDICATION HISTORY

1) **Do you take any medications?**
   a. Yes
   b. No

1a) Please list all medications you take with or without prescription:

Medication	Dose/Strength	When do you take it?	Reason you take the medication

2) **Please enter the date of your last pneumonia vaccination:** _____

3) **Please enter the date of your last influenza vaccination**: _____

4) **If you declined a vaccination please circle why:**
   a. Vaccine not available or other system reasons
   b. Patient allergy or other medical
   c. Patient declined or other patient reasons

PREFERRED PHARMACY

5) **What is your preferred pharmacy?** _____

6) Address: _____

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1) Do you have symptoms in the following areas? (Please choose all that apply or select "None" if no previous symptoms)

Constitutional			Ears/Nose/Throat			Eyes			Cardiovascular			Respiratory		
Recent Weight Change	Yes	No	Hearing Loss or Ringing	Yes	No	Wear Glasses/Contacts	Yes	No	Chest Pain	Yes	No	Shortness of Breath	Yes	No
Night Sweats/Fevers	Yes	No	Sinus Problems	Yes	No	Blurred/Double Vision	Yes	No	Palpitations	Yes	No	Cough	Yes	No
Fatigue	Yes	No	Nose Bleeds	Yes	No	Eye Disease or Injury	Yes	No	Heart Trouble	Yes	No	Coughing up blood	Yes	No
			Sore Throat/Voice Change	Yes	No				Swelling Hands/Feet	Yes	No			

Gastrointestinal			Musculoskeletal			Neurological			Integumentary (Skin/Breast)			Endocrine		
Nausea/Vomiting	Yes	No	Muscle Pain or Cramps	Yes	No	Frequent Headaches	Yes	No	Change in Hair or Nails	Yes	No	Excessive Thirst/Urination	Yes	No
Abdominal Pain	Yes	No	Stiffness/Swelling Joints	Yes	No	Paralysis or Tremors	Yes	No	Rashes or Itching	Yes	No	Hormone Problems	Yes	No
Bowel Problems	Yes	No	Joint Pain	Yes	No	Numbness/Tingling	Yes	No	Breast Lump	Yes	No			
			Trouble Walking	Yes	No				Breast Pain or Discharge	Yes	No			

Hematologic/ Lymphatic:			Allergic/ Immunologic:			Genitourinary - Male Only:			Genitourinary - Female Only:			Psychiatric:		
Bruise Easily	Yes	No	Food Allergies	Yes	No	Blood in Urine	Yes	No	Blood in Urine	Yes	No	Insomnia	Yes	No
Slow to Heal	Yes	No	Aspirin Allergies	Yes	No	Kidney Stones	Yes	No	Kidney Stones	Yes	No	Confusion/Memory Loss	Yes	No
Enlarged Glands	Yes	No	Antibiotic Allergies	Yes	No	Sexual Problems	Yes	No	Sexual Problems	Yes	No	Anxiety		
						Testicle Pain	Yes	No	Menstrual Pain	Yes	No	Substance Abuse		