Primary Health Solutions – Comprehensive Health Assessment – ADULT (19+ Years Old)

PATIENT:

Last Name:	First Name:	Nickname:	Date of Birth: MM/DD/YYYY	Date Completed: MM/DD/YYYY

Current Medications: (Name and Dose) *Include prescription, over the counter medications, vitamins and herbal preparations*	**Allergies:** *Please list all allergies including medication, environmental, food and insect*

Hospitalizations, Surgeries, Serious Injuries:	**Year:**	**Last Exam:** *Please list well visits, dental, vision, PAP, mammogram, colon cancer screening, etc.*	**Provider:**	**Date:**

Check conditions below that you have now or have had in the past:

□ Alcoholism	□ Diabetes, Type: 1 2 Last HgA1c:	□ High Cholesterol	□ Stomach Problems
□ Allergies	□ Dizziness, light headed or passing out	□ Hives/Skin Rash	□ Stroke
□ Anemia	□ Drug Addiction	□ Kidney Disease	□ Tuberculosis
□ Arthritis	□ Epilepsy/Seizures	□ Lung Disease	□ Thyroid Problems
□ Asthma	□ Genital Discharge/Pain	□ Mental Health problems Describe:_____	□ Ulcer
□ Bleeding Disorder	□ Heart Disease/Heart Attack	□ Migraines/Chronic Headaches	□ Urinary Problems/Pain
□ Blood Clot in Leg/Lung	□ Heart Murmur	□ Rheumatic Fever	□ Other:
□ Blood Disease/Disorder	□ Hepatitis, Type: A B C	□ Sexually Transmitted Infection	_____
□ Cancer, Type: _____	□ High Blood Pressure	□ Sinus Trouble	_____

Family History: *Check if any family members have had any of the following and their relationship to you*

□ Alcoholism	Relationship: _____	□ Heart Disease / Heart Attack	Relationship: _____
□ Cancer, Type: _____	Relationship: _____	□ High Blood Pressure	Relationship: _____
□ Depression	Relationship: _____	□ Lung Disease	Relationship: _____
□ Diabetes	Relationship: _____	□ Mental Health Problems	Relationship: _____
□ Drug Addiction	Relationship: _____	□ Stroke	Relationship: _____
□ Glaucoma	Relationship: _____	□ Other: _____	Relationship: _____

Social Habits:

Do you smoke? □ Yes □ No
Do you use smokeless tobacco? □ Yes □ No
Do you vape? □ Yes □ No
Are you exposed to second hand smoke? □ Yes □ No
Illegal drug use? □ Yes □ No
Do you use alcohol? □ Yes □ No
How many times do you use products containing caffeine? _____

Male Health: □N/A

Last Prostate Exam: Date: _____
Do you perform self testicular exams? □ Yes □ No

Nutrition: *Please check all that apply*

Special diet? □ If yes, describe _____
Significant weight change in the past 6 months? □ Gain □ Loss
Pounds: _____
Do you have problems with chewing or swallowing? □ Yes □ No
If yes, describe: _____
Do you get enough to eat? □ Yes □ No

Female Health: □N/A

Are you pregnant? □ Yes □ No If yes, due date: _____
Last menstrual period: _____
Age of first menstrual period: _____
Birth control: □ None □ Pills □ Other _____
# of pregnancies: _____
# of living children: _____
Last mammogram: Date: _____ □ Normal □ Abnormal
Last pap smear: Date: _____ □ Normal □ Abnormal
Do you perform self breast exams? □ Yes □ No
# of live births: _____ # of miscarriage/abortions: _____

Primary Health Solutions – Comprehensive Health Assessment – ADULT (19+ Years Old)

PATIENT:

Last Name:	First Name:	Nickname:	Date of Birth: MM/DD/YYYY	Date Completed: MM/DD/YYYY

Dental: *Please check all that apply*

Prosthetic heart valve	□	Describe: _____
Artificial joint	□	Describe: _____
HIV/AIDS	□	Describe: _____
Pacemaker	□	Describe: _____
Herpes/cold sores	□	Describe: _____
Sickle cell	□	Describe: _____
Oral sores/bleeding gums	□	Describe: _____

When were your last dental x-rays? _____

Are you currently experiencing dental pain or discomfort? □ Yes □ No

Do you have clicking, popping or discomfort in the jaw? □ Yes □ No

Have you ever had a serious injury to your head or mouth? □ Yes □ No

Do you wear dentures or partials? □ Yes □ No

Vision: *Please check all that apply*

Itching	□	Describe: _____
Tearing/burning	□	Describe: _____
Double vision	□	Describe: _____
Blurry vision	□	Describe: _____
Floaters	□	Describe: _____
Flashes	□	Describe: _____
History of eye trauma or eye surgery	□	Describe: _____
History of cataracts	□	Describe: _____
History of glaucoma	□	Describe: _____

Misc:

Do you have trouble with any of the following?

□ Food □ Utilities □ Housing □ Transportation □ Clothing

What is your highest level of education?

□ Less than high school □ Completed high school/GED

□ More than high school

Other Information:

Do you feel isolated? □ Yes □ No

Do you have social anxiety? □ Yes □ No

Are you sexually active? □ Yes □ No

Do you have unprotected sex? □ Yes □ No

Do you forget to take your medications? □ Yes □ No

Have you had more than 2 emergency room/hospital visits in the last 30 days? □ Yes □ No

Do you live independently or with a caretaker? _____

Do you feel physically and emotionally safe where you live? □ Yes □ No

How often do you see or talk to people you care about or feel close to? _____

In the past year, have you been afraid of your partner or ex-partner? □ Yes □ No

Communication Needs:

Are you hearing impaired? □ Yes □ No

Are you visually impaired? □ Yes □ No

Do you have trouble remembering? □ Yes □ No

Do you have trouble learning new things? □ Yes □ No

Do you have trouble concentrating? □ Yes □ No

Do you have trouble making decisions? □ Yes □ No

Cultural/Religious Needs and Preferences: *Please list*

Do you have advanced directives? □ Yes □ No

If so, please provide a copy to PHS.

Do you consent to blood products? □ Yes □ No

Are you under the care of another provider? □ Yes □ No If yes, provider name: _____

Are you under the care of a dentist? □ Yes □ No If yes, provider name: _____

FOR STAFF USE ONLY

Provider Name and Credentials: _____ Date: _____

Provider Signature: _____

Provider Name and Credentials: _____ Date: _____

Provider Signature: _____