PATIENT SELF-ASSESSMENT FORM FOR INITIAL PRIMARY CARE OUT-PATIENT VISIT

We ask that all of our patients fill out this form prior to the first visit. Please do your best to answer all of the questions. Everything is CONFIDENTIAL and part of your medical record.

Name:	Date of Birth:	Visit Date:
Reason for Visit/CC:		
History of Present Illness:		
• *Any Pain?* ☐ no ☐ yes *If yes, how severe?* ☐ mild (1-3) ☐ moderate (4-6) ☐ severe (7-10)		
• Where is the pain?		

Review of Systems: *Have you had…*

• **CONSTITUTIONAL**	**YES**	**NO**	• **EYES**	**YES**	**NO**
Any recent weight change	☐	☐	Vision changes in past 6 months	☐	☐
Fatigue> 6 months	☐	☐	Wear glasses/ contact lenses	☐	☐
• **RESPIRATORY**			• **EARS/NOSE/THROAT**		
Chronic/ frequent cough	☐	☐	Change in hearing in past 6 months	☐	☐
Shortness of Breath	☐	☐	Voice change	☐	☐
• **CARDIOVASCULAR**			Frequent nose bleeds	☐	☐
Chest pain	☐	☐	• **GASTROINTESTINAL**		
Palpitation/ irregular heart beat	☐	☐	Nausea/; vomiting	☐	☐
Cannot climb 2 flights of stairs	☐	☐	Change in bowel habits	☐	☐
• **MUSCULOSCKELETAL**			• **GENTOURINARY**		
Painful/ swollen joints	☐	☐	Blood in urine	☐	☐
Difficulty in walking	☐	☐	Difficulty holding urine	☐	☐
• **NEUROLOGICAL**			• **PSYCHIATRIC**		
Chronic/ frequent headaches	☐	☐	Feeling depressed/ sad lately	☐	☐
Convulsions/ seizures	☐	☐	Nervous/ anxious	☐	☐
Memory problems	☐	☐	Suicide attempt	☐	☐
• **ENDOCRINE**			• **SKIN**		
Any loss in height	☐	☐	Hair loss/ excessive hair growth	☐	☐
Excessive thirst/ urination	☐	☐	Rashes/ itching	☐	☐
• **FOR WOMEN ONLY**			• **FOR MEN ONLY**		
Abnormal vaginal discharge	☐	☐	Discharge from penis	☐	☐
Discharge/ lump in breast	☐	☐	Lump on testicles	☐	☐

PREVENTIVE HEALTH	YES	NO	Date Done	**SOCIAL HISTORY**	YES	NO	Comments
Tetanus-diphtheria vaccine every 10 yrs				Present or past alcohol use			
Pneumococcal 23 vaccine (once)				Past or Present smoking			
Influenza vaccine (yearly Oct-Nov)				Assistive devices			
Prevnar 13 vaccine (once)				Regular exercise			
Hepatitis B vaccine				Any religious concerns			
Colonoscopy/ sigmoidoscopy				Any cultural concerns			
Breast exam/ mammogram				Healthcare proxy			

Highest level of Education:

Prior Work/Hobbies/Military Service:

Procedures/Surgeries: Dates	**FOR WOMEN ONLY:**
	# Pregnancies:
	# Miscarriages/ Abortions:
	# Live Births:
	Age of Menopause:

PREFERRED PHARMACY:

ALLERGIES TO FOOD/MEDICINE: YES NO

Specify allergies:

MEDICATIONS: (please attach a list of medications/ over the counter medications and any supplements)

Other doctors/Specialist Consultants: Please attach list names, specialty, address, phone numbers

Advance Directive: Attach copy of POLST **CODE STATUS**: Full code or Natural Death

To the best of my knowledge, the questions on this form have been accurately answered, I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

I also authorize the healthcare staff to perform the necessary services I may need.

DATE: Above information reviewed and confirmed with the patient.

Signature of Patient/ Guardian:	**Signature of Medical Staff:**

Patient Name: _____