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

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

Name:	DOB:	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?		
Please list your medication allergies as well as other allergies (food, environmental) and the reaction that occurs:		
Advanced Directive on File? Yes/No	POLST on file? FULL CODE / DNR	
Have you been hospitalized in the last 30 days? Yes / No If yes what was diagnosis:		

FAMILY HISTORY: Has a member of your family had any of the following medical conditions? Please only include biological parents, grandparents, siblings, and children

Problem	Circle Yes or No		Relationship/Age of Onset
Alcohol/Drug Abuse	Yes	No	
Arthritis/Joint problems	Yes	No	
Asthma or Lung disease	Yes	No	
Blood disorder (e.g. anemia)	Yes	No	
Cancer (specify type)	Yes	No	
Dementia (e.g. Alzheimer's)	Yes	No	
Depression/Mental illness	Yes	No	
Diabetes	Yes	No	
Gastrointestinal problems	Yes	No	
Genitourinary problems	Yes	No	

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Heart disease (e.g. heart attack, artery disease or arrhythmia)	Yes	No	
High blood pressure	Yes	No	
High cholesterol	Yes	No	
Liver disease	Yes	No	
Neurological Disorder	Yes	No	
Osteoporosis	Yes	No	
Seizure Disorder	Yes	No	
Stroke	Yes	No	
Thyroid Disease	Yes	No	
Other:	Yes	No	

Review of Systems: *Have you Had…..*					
CONSTITUTIONAL			**EYES**		
Any recent weight change	Yes	No	Vision changes in past 6 months	Yes	No
Fatigue > 6 months	Yes	No	Wears contacts/glasses	Yes	No
RESPIRATORY			**EAR/NOSE/THROAT**		
Chronic/ frequent cough	Yes	No	Change in hearing in past 6 months	Yes	No
Shortness of Breath	Yes	No	Voice change	Yes	No
Wheezing	Yes	No	Frequent Nose Bleeds	Yes	No
CARDIOVASCULAR			**GASTROINTESTINAL**		
Palpitation/ irregular heart beat	Yes	No	Nausea/Vomiting	Yes	No
Cannot climb 2 flights of stairs	Yes	No	Change in Bowel Habbits	Yes	No
Chest Pain	Yes	No			
MUSCULOSCKELETAL			**GENTOURINARY**		
Painful/ swollen joints	Yes	No	Blood In urine	Yes	No
Difficulty in walking	Yes	No	Difficulty holding urine	Yes	No
NEUROLOGICAL			**PSYCHIATRIC**		

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Chronic/ frequent headaches	Yes	No	Feeling depressed/ sad lately	Yes	No
Convulsions/ seizures	Yes	No	Nervous/Anxious	Yes	No
Memory problems	Yes	No	Suicide Attempt/Ideation	Yes	No
ENDOCRINE			SKIN		
Any loss in height	Yes	No	Hair loss/ excessive hair growth	Yes	No
Excessive thirst/ urination	Yes	No	Rashes/Itching	Yes	No
FOR WOMEN ONLY			**FOR MEN ONLY**		
Abnormal vaginal discharge	Yes	No	Discharge from penis	Yes	No
Discharge/ lump in breast	Yes	No	Lump on testicles	Yes	No

Preventative Health	**Yes Or No**		**Date Done**
Tetnus-Diptheria vaccine (every 10 years)	Yes	No	
Pneumococcal 23 Vaccine (Once)	Yes	No	
Influenza Vaccine (annually Oct-Nov)	Yes	No	
Prevnar 13 Vaccine (once)	Yes	No	
Hepatitis B Vaccine	Yes	No	
COVID-19 Vaccine	Yes	No	
Colonoscopy/Sigmoidoscopy	Yes	No	
Breast Exam/Mammogram	Yes	No	

Social History	**Yes Or No**		**Comments**
Assistive Devices	Yes	No	
Regular Exercise	Yes	No	
Religious Concerns	Yes	No	
Cultural Concerns	Yes	No	
Healthcare Proxy	Yes	No	

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 to any changes in my medical status.

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

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Signature of Patient/Gardian:

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