

PATIENT HEALTH HISTORY

PLEASE PRINT ALL INFORMATION



Clinic _____

Date: / /

Name:	Birthdate: / /
Racial/Ethnic Background:	Occupation:
Primary Language:	Interpreter needed? Y N
Date of Last Physical Exam: / /	Where:
Referring Doctor:	

List any allergies to medications, or anything else, including latex and describe your reaction _____

LATEX ALLERGY PRE-SCREEN

1. Do you ever have a rash, redness, or swelling after use of gloves, lasting 1-2 days? **Y N**
2. Do you have allergies, asthma, rhinitis after use of rubber, latex products? **Y N**
3. Do you have frequent contact with rubber, latex products? **Y N**
4. Do you have allergic reactions to any of the following foods: avocados, bananas, chestnuts, papaya, kiwi, hazelnut, cherry, or peach? **Y N**

Nutrition Screening Questions <ul style="list-style-type: none">• Have you lost more than 10lbs. in the last 6 months without trying? Y N• Do you have any open sores that are not healing? (decubitis) Y N• Are you having difficulty in chewing or swallowing that is affecting your food intake? Y N• Is a nutritional assessment necessary? Y N (To be completed by practitioner)	Pain Assessment Screening: <ul style="list-style-type: none">• Are you experiencing any pain? Y N• Is a pain assessment necessary? Y N (to be completed by nurse/practitioner)
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Functional/Mental/Psycho/Social Assessment:

Do you live alone? **Y N** Whom do you rely on for emotional/social support? _____

Have you had any changes in your life that could affect your coping abilities? (job, move, divorce, death, disabilities) **Y N** If yes explain: _____

Are you able to care for yourself without the assistance of anyone else? _____

Do you require any assistive devices such as wheelchair, walker, cane, etc. _____

Do you have any social, cultural, religious, beliefs or values that may affect your treatment plan or healthcare needs? _____

Abuse Assessment Screen:

- Have you felt unsafe where you have been living? **Y N** Explain: _____
- Have you been emotionally, physically, or sexually hurt by anyone? **Y N**

Do you have a Living Will? Y N	Do you have a durable power of attorney for your health care? Y N
Have you provided this office with a copy? Y N	Would you like information on this? Y N

Immunizations:

DATE OF LAST: Flu Vaccine _____ Pneumonia Vaccine _____ Tetanus Vaccine _____

