Medical Assessment

Date: _____ Time: _____

Patient Name: _____Date of Birth: _____

Gender: Male Female Transgender Accompanied by: _____

Primary Care Doctor: _____ Phone: _____

Other Medical/therapist/psychiatrists (name/phone): _____

_____

Allergies: (include medications, food, contrast, environmental): _____

Current Medications (include name, dose, time of day taken, include over the counter medications):

Name of medication	Dose	Last time taken	What are you taking it for?

Have you had any medication changes in the past 7 days? Yes / No

Are you taking your medication as prescribed? Yes / No

Height: _____ Weight: _____

Do you have scars, cuts, wounds, tattoo's, piercing's? Yes / No

If yes, explain: _____

Do you have problems with breathing, like asthma, shortness of breath, oxygen use, and colds? Yes / No

If yes, explain: _____

Do you drink alcohol or use illegal drugs? ☐ Yes / ☐ No

If yes, what was the substance: _____ date/time used: _____

Amount used/drank: _____

Have you experienced any of the following in the last 7 days?

Fever greater than 100.4	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Persistent cough greater than 3 weeks	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Nights sweats	☐ Yes	☐ No
Cough with blood produced	☐ Yes	☐ No
Unexplained weight loss	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Body Aches	☐ Yes	☐ No
Rash	☐ Yes	☐ No
Nasal Congestion	☐ Yes	☐ No
Do you have a prior history of TB or positive TB skin test?	☐ Yes	☐ No
Have you had close contact with a person who has TB?	☐ Yes	☐ No
Have you had close contact with any person having flu like illness?	☐ Yes	☐ No
Have you been test HIV positive?	☐ Yes	☐ No

Immunization Information: have you or your child been vaccinated for the following

Mumps		☐ Yes	☐ No
Measles		☐ Yes	☐ No
Rubella		☐ Yes	☐ No
Chicken Pox		☐ Yes	☐ No
Hepatitis		☐ Yes	☐ No
Tetanus	date of last _____	☐ Yes	☐ No
Flu	date of last _____	☐ Yes	☐ No