CUSTOMER'S MEDICAL HISTORY SCREEN

Customer Name: _____ (please print) **Current Date: ____/____/_____**

Client ID: _____DOB: ____/____/____ **Gender: ☐ Male ☐ Female**

PHYSICIAN INFORMATION

Family Physician/Practice Name:_____Date Last Seen: __/__/____

Would you like us to coordinate services with your family physician? ☐Yes ☐No Is there a release? ☐Yes ☐No

☐ No Family Physician/Practice ☐ Would like a referral? Are your Immunizations up-to-date? ☐Yes ☐No

Do you have an advance directive for health care?

☐Yes A copy for your record is requested. ☐No

Would you like information regarding advance directives? ☐Yes ☐No

MEDICAL HISTORY

DIRECTIONS: PLEASE CHECK THE APPROPRIATE BOX BELOW

Vision	I can see fine detail, including regular print in newspapers/books	I can see large print, but not regular print in newspapers/books	I am not able to see large print, but I can identify objects around me	I have minimal object identification. I can follow objects, and can see only light, colors, and shapes	I can't see/ Can't see well enough to identify anything
How well can you see? (With any glass or visual aids)	☐	☐	☐	☐	☐

Do you use a Visual Aid/ glasses? Yes ☐ No ☐

Hearing	I have no difficulty hearing in normal conversations, social interaction, listening to TV, etc.	It is difficulty to hear a person six feet away or a person speaking	I have problems hearing normal conversation, I require quiet to hear well	The speaker must speak loudly and slowly in order for me understand	I can't hear
How well can you hear? (With any hearing aids)	☐	☐	☐	☐	☐

Do you use a Hearing Aid? Yes ☐ No ☐

Allergies
List any allergies to food or medicine and describe reaction (If none, write none):

_____
_____
_____
_____
_____
_____

Surgery
Please list any surgeries or medical hospitalizations with date (If known):

_____
_____
_____
_____
_____
_____

Hypertension (High Blood Pressure)	
☐	Never present
☐	History of condition, but not treated for the condition within the past 12months
☐	Treated for condition within the past 12 months and blood pressure is stable
☐	Treated for condition within the past 12 months, but blood pressure remains high or unstable

Seizure Disorder or Epilepsy	
☐	Never present
☐	History of condition, but not treated for the condition within the past 12 months
☐	Treated for the condition within the past 12 months and seizure free
☐	Treated for the condition within the past 12 months, but still experience occasional seizures (less than one per month)
☐	Treated for the condition within the past 12 months, but still experience frequent seizures

Progressive Neurological Disease i.e. Dementia, Parkinson's, Alzheimer's	
☐	Not present
☐	Treated for the condition within the past 12 months
☐	Any head trauma

Pregnancy
Are you or could you be pregnant? ☐Yes ☐No

Date of last menstrual cycle: __/__/____
☐ Not applicable – Menopause

# of pregnancies to date: ____

Do you have any children under 18?
☐ Yes
☐No

SMOKING STATUS: (Age 13 and over)

What is your current smoking status?
☐ Current every day smoker
☐ Currently smoke some days

☐ Former smoker
☐ Never smoked

If you currently smoke: how many packs a day? _____
Do you want to quit? ☐ Yes ☐ No
Are you interested in educational resources on smoking related topics? ☐ Yes ☐ No

If you are a former smoker: how long have you quit smoking? _____

DIRECTIONS: PLEASE CHECK THE APPROPRIATE BOX BELOW

Health Condition	The condition has never been present	There is a history of the condition, but have not received treatment in the past 12 months	I have received treatment for this condition within the last 12 months
Asthma	☐	☐	☐
Pneumonia (2 or more times within the past 12 months)	☐	☐	☐
Upper Respiratory Infections	☐	☐	☐
Diabetes ☐Type 1 ☐Type 2	☐	☐	☐
Gastro Esophageal Reflux (GERD)	☐	☐	☐
Chronic Bowel Impaction	☐	☐	☐
Headaches/Migraines	☐	☐	☐
Stroke	☐	☐	☐
Anemia/Bleeding Disorders	☐	☐	☐
Kidney/Bladder Problems	☐	☐	☐
Hepatitis ☐**A** ☐**B**☐ **C**	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid Problems	☐	☐	☐
Cancer	☐	☐	☐
Heart Disease	☐	☐	☐
Sleep Disorders/Problems	☐	☐	☐
Untreated Dental Problems	☐	☐	☐
STI (Sexually Transmitted Infection)	☐	☐	☐
Delirium/High Fever	☐	☐	☐

Other Medical Conditions
Please provide description for any medical conditions not listed: _____
_____

NUTRITION

Height: _____Ft._____In. Weight_____lbs.

DIRECTIONS: PLEASE CHECK YES OR NO FOR EACH QUESTION

Without wanting to, have you lost or gained 20 pounds or more in the last six months? ☐Yes ☐No
I have experienced a change in my appetite ☐Yes ☐No
I am supposed to follow a special diet but have not been doing so ☐Yes ☐No
I have food allergies ☐Yes ☐No

IF YOU HAVE MEDICAID, YOU ARE ELIGIBLE TO WORK WITH A PEER SUPPORT SPECIALIST WHO WILL HELP YOU IDENTIFY AND PROVIDE SUPPORT AND COACHING IN ORDER TO HELP YOU REACH YOUR HEALTH & WELLNESS GOALS.
ARE YOU INTERESTED IN THIS SERVICE? ☐ YES ☐ NO

MEDICATIONS

DIRECTIONS: LIST ALL THAT YOU ARE CURRENTLY TAKING INCLUDING PRESCRIPTIONS, ORAL CONTRACEPTIVES, HERBAL PRODUCTS AND OVER THE COUNTER MEDICATIONS.

☐ (Check this box if there are no current medications)

Medication	Dosage	How Often	Route	Reason for Taking	Prescribing Doctor
			☐Oral ☐Injection ☐Topical ☐Inhalation ☐Other		
			☐Oral ☐Injection ☐Topical ☐Inhalation ☐Other		
			☐Oral ☐Injection ☐Topical ☐Inhalation ☐Other		
			☐Oral ☐Injection ☐Topical ☐Inhalation ☐Other		

CHEMICAL USAGE SCREEN: (Check all that apply)

☐ Have you spent more time drinking or using than you intended to?

☐ Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?

☐ Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

☐ Has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use?

☐ Have you found yourself thinking a lot about drinking or using?

☐ Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?

☐ Do you go to AA, NA, or other celebrate, recovery, or smart recovery? _____ Community Groups? _____

If yes, how often?

COMMUNICABLE DISEASE RISK ASSESSMENT

Have you had:

☐ Unprotected sexual relations with more than one partner during the past 24 months?

☐ Sexual relations with anyone who is infected with HIV/AIDS, Hepatitis, or an STD?

☐ Sexual relations with anyone who injects drugs?

☐ Injected drugs or shared needles?

☐ Received money, drugs, or other favors for sexual relations?

*Having checked any of the above risk factors may have put you at risk of a communicable disease such as HIV/AIDS, STDs, Hepatitis B or C, or TB. **The Community Health Department is available to provide**

confidential testing and/or vaccinations at 570 N Marshall, Coldwater. Their phone number is 517-279-9561, ext. 143.

If you checked at least one box above, please indicate your preferred response(s):

☐ I would like more information about my risk of communicable disease ☐

☐ I understand that I may be at risk (I checked at least one box above) but am not interested in referrals or information

☐ I plan to follow-up with the suggestion to get testing at the Community Health Department.

PAIN ASSESSMENT

Are you in physical pain currently? ☐Yes ☐No

If yes, please mark your pain level using the scale below:

Are you under a doctor's care for the pain? ☐Yes ☐ No

If yes, who is the doctor?_____

Signature of

Customer/Person Completing Form:_____ Date: _____