Health Assessment

Name: ______________________ **Date of Exam:** ______________________

ID#: ____________ **Sex: M F** **Date of Birth:** ______________________

Physical Assessment

Weight: ____________

Height: ____________

Temp: ____________

Pulse: ____________

BP: ____________

Nutritional Assessment

Diet: ☐ **Regular** ☐ **Restricted:** *Type/Amount*

Type	*Amount*	*Type*	*Amount*
☐ NPO:	____________	☐ Sodium:	____________
☐ Soft:	____________	☐ Calories:	____________
☐ Diabetic:	____________	☐ Caffeine:	____________
☐ Cholesterol:	____________	☐ Other:	____________

REVIEW OF SYSTEMS: Please make comments and check all that apply.

Cardiovascular Conditions

Heart tones:

- ☐ Strong
- ☐ Regular
- ☐ Irregular
- ☐ Murmur
- ☐ Other: ____________

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- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Low blood Pressure
- ☐ Heart Defects
- ☐ Heart Disease
- ☐ Other: ____________

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Genito-urinary Conditions

- ☐ Bladder
- ☐ Incontinent
- ☐ Kidney
- ☐ Neurogenic Bladder
- ☐ Prostrate
- ☐ Renal
- ☐ UTI (4+/year)
- ☐ Other: ____________

Allergies

- ☐ Type: ____________
- ☐ Drug: ____________
- ☐ Treatment for allergies:

____

Gastrointestinal Conditions

- ☐ Acid Reflux
- ☐ Chronic Constipation
- ☐ Chronic Diarrhea
- ☐ Colitis
- ☐ G-Tube
- ☐ Gall Stones
- ☐ GERD
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ IBS
- ☐ Liver Difficulties
- ☐ Malabsorption Diseases
- ☐ Pancreatitus
- ☐ Ulcers
- ☐ Other: ____________

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Respiratory Conditions

- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Dyspnea
- ☐ Emphysema
- ☐ Fibrosis
- ☐ Pulmonary Edema
- ☐ Sleep Apnea
- ☐ Cystic Fibrosis
- ☐ Other: ____________

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Psychiatric Conditions

- ☐ Psychosis
- ☐ Depression
- ☐ Bi-Polar
- ☐ ADD
- ☐ ADHD
- ☐ Insomnia
- ☐ Other: ____________

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Neurological Conditions

Speech

- ☐ Verbal
- ☐ Non-verbal

- ☐ Seizures

  Type: ____________
- ☐ Dementia: ____________
- ☐ Other: ____________

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Musculoskeletal Conditions

- ☐ Arthritis
- ☐ Joint pain
- ☐ Muscle pain/cramps
- ☐ Difficulty walking
- ☐ Work limitations

  Stand: ____________

  Lift: ____________

  Other: ____________
- ☐ Other: ____________

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Reproductive Systems
- ☐ STD
- ☐ Perimenopausal
- ☐ Postmenopausal
- ☐ Other ______________

Endocrine Conditions
- ☐ Diabetes
- ☐ Thyroid
- ☐ Glandular
- ☐ Hormonal
- ☐ Other ______________

Skin Conditions
- ☐ Skin Carcinomas
- ☐ Cysts
- ☐ Mole Mapping
- ☐ Skin Tumors
- ☐ Other ______________

Recommendations for Follow-up
- ☐ OT
- ☐ PT
- ☐ Dental
- ☐ Eyes
- ☐ Neurologist
- ☐ Podiatrist
- ☐ Pap Smear
- ☐ Psychological
- ☐ Immunizations ______________
- ☐ Hearing
- ☐ Mammogram
- ☐ TB Test
- ☐ Dermatology
- ☐ Other: ______________
- ☐ Speech
- ☐ Dietician
- ☐ Labs ______________
- ☐ Colonoscopy
- ☐ Bone Density
- ☐ Gynecologist
- ☐ Other: ______________

Disability:

Present Diagnosis:

Current Medications:

Medication	Dosage	Purpose

______________________________ ______________
Physician's Signature **Date**

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Printed Name of Physician