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): ____

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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