Patient Assessment

Patient Information	
Name:	
Date of birth:	**Gender:**
Occupation:	**Mobile number:**
Height: **Weight:**	**Race/Ethnicity:**
Reason for visit:	

Social Habits	
Alcohol: ◯ **No** ◯ **Yes** (frequency):	
Cocaine: ◯ **No** ◯ **Yes**	**Narcotics/Drug use:** ◯ **No** ◯ **Yes**
Smokes Tobacco: ◯ **No** ◯ **Yes** If yes, # of years: # of packs a day: When stopped:	
Cultural/religious beliefs that may affect care ◯ **No** ◯ **Yes** (please specify)	
Do you prefer to learn by: ☐ Seeing (TV, Video, Written) ☐ Hearing (Audio) ☐ Doing (Hands On)	
Do you have any barriers to learning (please check): ☐ Physical ☐ Emotional ☐ Vision ☐ Financial ☐ Hearing ☐ Cognitive	

Hospitalization/Surgery/Major Illness

Problem	Year	Where treated	Days in hospital

Gynecologic/Obstetric History
Any Pregnancies? ◯ **No** ◯ **Yes** (how many)
How many children have you given birth to?
How many abortions/miscarriages?
Going through menopause? ◯ **No** ◯ **Yes**
Date of last period:
Monthly breast exams? ◯ **No** ◯ **Yes**
Lumps on breasts? ◯ **No** ◯ **Yes**
Date of last mammogram:

Patient Assessment

Medications (Please list all medications you are currently taking, including vitamins and supplements)
1.
2.
3.
4.
5.
Any previous bleeding problems? ◯ **No** ◯ **Yes**
Have you used herbal medications? ◯ **No** ◯ **Yes**
Any allergy to medication? ◯ **No** ◯ **Yes** (type of reaction)
Any food allergies? ◯ **No** ◯ **Yes** (please specify)
Nutritional Data
Are you following a special diet? ◯ **No** ◯ **Yes** (please specify)
Unintentional Weight ◯ Over/Under 5 lbs in 1 month ◯ Over/Under 10 lbs in 3-6 months
Appetite ◯ Good (eat 3+ meals/day) ◯ Fair (1-2 meals/day) ◯ Poor (less than 1 meal/day)

Personal/Family History		
IF YES	**Patient/How often**	**Family/How often**
Allergies		
Amputation		
Anesthesia Problems		
Angina		
Anxiety or Depression		
Asthma		
Bleeding/Bruising Problems		
Bowel Problems		
Cancer		
Chest Pain/Heart Disease		
Diabetes Mellitis		
Dizziness		
Ear Problems		
Eye Problems		
Headaches		
Heartburn		
Hepatitis		

Patient Assessment

Personal/Family History		
IF YES	**Patient/How often**	**Family/How often**
High Blood Pressure		
Hyperthermia/Hyperpyrexia (malignant)		
Kidney Disease		
Known Genetic Disorder		
Mental Retardation/Illness		
Moles that are changing		
Nasal Problems		
Pain in Joints/Limbs		
Persistent Cough/Wheezing		
Prostate Enlargement		
Rashes, Sores, Itching		
Ringing in Ears		
Seizure Disorder		
Shortness of Breath		
Skin Problems		
Stroke		
Thyroid Problems		
Trouble Sleeping		
Tuberculosis/Lung Disease		
Stomach/Leg Ulcers		
Urination Problems		
Weakness/Numbness		
OTHER:		

ADDITIONAL NOTES:

Completed by:	**Date:**