HEALTH CARE FOR THE HOMELESS
HISTORY AND PHYSICAL FORM

DATE | TIME:

DATE OF BIRTH: | SS#: | GENDER: ☐Male ☐Female ☐Other | RACE: ☐ Black ☐ White ☐ Hispanic ☐Other:

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS (DATE OF ONSET, SYMPTOMS, PRECIPITATING FACTORS, ETC.):

PAIN: ☐ **No** ☐ **Yes** - Location

Parn Score (check one) (1) **(2) (3) (4)** (5) **(6) (7)** (8)(9)(10)

REVIEW OF SYSTEMS (check, if present):

☐ Dizziness	☐ Mouth/Gum/Teeth	☐ Bruise or Bleed Easily
☐ Fainting or Falling Out Spells	☐ Throat problem	☐ Blood inUrine/Red or Dark Urrne
☐ Headaches/Migraines	☐ Shortness of breath	☐ Painful/Difficult Urination
☐ Numbness/Tingling Arms and Legs	☐ Wheezing	☐ Problem Starting/StoppingUrination
☐ Weakness/Frequent Tiredness	☐ Chest Pain or tightness	☐ Excessive Urine/Excessive Thirst
☐ Swollen Glands	Cl Palpitations	☐ Lose Urine on Coughing or Sneezing
☐ Frequent Fever or Sweats	☐ Ankle/Leg swelling	U > 2 Nighttime Urination
☐ Night Sweat	☐ Abdominal Pain	☐ Lump/Discharge/Pain in the Breasts
☐ Cough or Phlegm	☐ Heartburn	☐ Lump in Vagina/Testicle
☐ Ever Coughed Up Blood	☐ Ever Vomited blood	☐ Itching/Discharge Vagina/Penis
☐ Lost Weight (>10lb. in < 1 yr.)	☐ Diarrhea	☐ Bleeding After Intercourse
☐ Problem Hearing	Cl Constipation	☐ Bleeding Between Periods
☐ Visual Problems	☐ Use Laxatives	☐ Painful Joints (arms, legs, back, knees hips)
☐ Hoarseness	☐ Black Stool	☐ Itching/Soreness/Changing mole or beauty mark
☐ Sinus problem	☐ Bloody Bowel movement	☐ Other:

MEDICAL PROBLEMS: Do you **have any of the following conditions (please check answer)**

	Yes	No	Year Dx		Yes	No	Year Dx
Anemia				Lung Disease			
Arthritis				Seizures			
Cancer				Skin Disorders			
Diabetes				Stomach/Gastrointestinal Problems			
Heart Disease				Stroke			
High Blood Pressure				Thyroid Disease			
Kidney/Bladder Problem				Psychiatric Problems/"Nerves"			

Any other Medical Diagnosis that were not covered:

Previous Hospitalizations/Surgeries/Injuries

Date	Problem	Place

CLIENT LAST NAME: | **FIRST:** | **HCH#:**

OB/GYN:

How many past pregnancies # Full Term	# Premature	# Abortions/Miscarriages	# Living Children:
Beginning Date of Last Menstrual Period		Was Last Menstrual Period Normal?	
Menopause? Onset?		If Client uses a Birth Control Method - Type?	
When was your Last Pap Test?		Was Last Pap Normal?	
When was your Last Mammogram?		Was Last Mammogram Normal?	

ALLERGIES: check all that apply - list name of allergens and describe symptoms

- ☐ Medications
- ☐ Food
- ☐ Chemicals
- ☐ Anesthetic Agents
- ☐ Vaccines

MEDICATIONS (Prescription & Non-Prescnptions) Include names, dosages, frequencies.

1	6
2	7
3	8.
4	9
5	10

HEALTH MAINTENANCE:

Vaccination History	Yes	No	Date
Measles, Mumps, Rubella (MMR)			
Last Tetanus Booster (Td)			
Hepatitis B			
Influenza (Flu vac)			
Pneumovax			
Other			

Tuberculosis History	Yes	No	Date
Any Known Exposure to M Tb?			
BCG/Tuberculosis Vaccination			
Last PPD (+)			
If (+) -was Prophylaxis given7			

If Yes, Type and Duration?

HIV HISTORY:

Date Last Tested.

Results. ☐ Negative ☐ Positive - If Positive, Date diagnosed: _____

Last CD4. _____ Last VL _____ How Contacted _____

FAMILY HISTORY **(check all that apply):**

	Father	Mother	Siblings	Others
died young				
anemia				
asthma				
bleeding tendency				
cancer (Type)				
diabetes				
glaucoma				

	Father	Mother	Siblings	Others
heart trouble				
high blood pressure				
kidney problem				
lung disease				
mental illness				
suicide				
substance abuse				

SOCIAL HISTORY (habit & lifestyle-alcohol, drugs, tobacco, exercise & sexual history):

Do you drink Alcohol? ☐ No ☐ Yes If yes, type and how much? _____ ☐ Stopped How long? _____

Any Rehab? ☐ No ☐ Yes

Have you ever felt you ought to CUT down on drinking? ☐ No ☐ Yes

Have people ANNOYED you by criticizing your drinking? ☐ No ☐ Yes

Have you ever felt bad or GUILTY about drinking? ☐ No ☐ Yes

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (EYE-OPENER)? ☐ No ☐ Yes

Have you ever had blackouts or done things you do not remember while drunk or high? ☐ No ☐ Yes

Have you ever taken **Drugs**? ☐ No ☐ Yes ☐ Current Use ☐ IPast Use What type and how much?

How do/did you taken them? ☐ Smoke ☐ Sniff ☐ inject ☐ Other

Have you ever shared needles/works? ☐ No ☐ Yes

Do you smoke/chew Tobacco7 ☐ NO ☐ Yes ☐ Quit

How many cigarettes per day and for how long? #_____ # days_____ # years_____

Do you Exercise regularly? ☐ No ☐ Yes - How often?

Have you ever had a Sexually Transmitted Disease? ☐ No ☐ Yes Diagnosis? _____ _____ _____

If yes how when and where treated?

Your Sexual Orientation ☐ Heterosexual ☐ Homosexual ☐]Bi-Sexual

How many partners have you had in the past yea' _____ in lifetime? Do you use cond' ☐ No ☐ Yes ☐ Sometimes

T °F	P	R	BP	Ht	Wt	FSG	PEFR	Visual Acuity: OU /20 OD /20 OS /20

CONSTITUTIONAL

☐ NORMAL: well-developed, well nourished, no acute distress

☐ ABNORMAL:

HEAD/NECK, EYES/FUNDI

☐ NORMAL: **Head** - NORMAL **Neck** -supple, full ROM, trachea midline; no thyromegaly, **Eyes** - sclera white, conjuctiva clear, no lid lag, PERRLA, PERRLA, **Fundi** - disc flat, no hemorrhages or exudates noted

☐ ABNORMAL:

MOUTH, EARS, NOSE & THROAT

☐ NORMAL: Ears; - lips pink and symmetrical, dentition good, oral mucosa pink and moist; tongue moist, no ulcer masses, tympanic membranes transluscent, non-bulging. and mobile b/l; canal walls pink, no discharge, hearing non-impaired Nose; mucosa and turbinates pink; septum midline Throat; soft and hard palates contiguous, no ulcer or lesion, salivary glands intact, gag reflex present

☐ ABNORMAL:

BREAST AND CHEST

☐ NORMAL: **Chest** - no deformrty, symmetrical; Breasts - no rashes, lumps, masses or tenderness, no nipple discharge

☐ ABNORMAL:

RESPIRATORY

☐ NORMAL: non-labored, no flatness, dullness or hyperresonance, tactile fremitus; clear to auscultation bilaterally

☐ ABNORMAL:

CARDIOVASCULAR

☐ NORMAL: no lifts, heaves or thrills; RRR; normal s1 & s2; NO MURMURS, RUBS, GALLOPS, Carotid pulses WNL, no bruit; Abdominal aorta normal size, no bruit; Femoral pulses WNL, no bruitt; **Pedal** pulses WNL, no varicosities or edema, BP+ / ; no orthostasis

☐ ABNORMAL:

GENITOURINARY

☐ NORMAL (male): Scrotum and Testes; no tenderness, swelling or masses, tests descended b/l; Penis -(un-)circumcised, no rashes/ulcers, no penile discharge; Prostate; non-enlarged, symmetrical, w/o nodularity or tenderness

☐ NORMAL (female): **Vulva**; no external masses, lesions, scars, rashes or swellings; Labia, Clitoris, **Vaginal**, and Urethral orifices normal and w/o discharge; Bladder - non-distended, non tender; Vagina - no discharge, no lesions; Cervix - no lesions or discharge, not inflammed, not friable on pap, no CMT; Uterus - normal size, nonpalpable masses, non-tender, b/l non-tender

☐ ABNORMAL:

ABDOMEN

☐ NORMAL: not distended, no scars, no rash, visible markings or distended vessels, non-tender, no hepatosplenomegaly, no masses, bowel sound normal Rectal: no skin tags, normal sphincter tone, no palpable lumps: Stool Hemoccult test: Negative ; Hernial Orifices: no hernia, cough impulse normal

☐ ABNORMAL:

MUSCULOSKELETAL

☐ NORMAL: Gait WNL; Digits, UE and LE w/o clubbing, cyanosis, misalignment, defects or deformities; Full ROM; no tenderness, contracture or crepitus; joint stable; no muscle atrophy or weakness

☐ ABNORMAL:

SKIN

☐ NORMAL: no rashes, lesions, ulcers, scars; warm and dry; normal turgor

☐ ABNORMAL:

LYMPHATICS

☐ NORMAL: no lymphadenopathy in neck, axilla, groin, etc.

☐ ABNORMAL:

NEUROLOGIC

☐ NORMAL: a & 0 X 3; Cranial nerves II XII intact; Sensation intact. Power 5/5 UE & LE b/l; DTR 2 + all groups b/l

☐ ABNORMAL:

PSYCHIATRIC

☐ NORMAL: Judgement and insight WNL; Recent and Remote memory intact, Mood and Affect WNL

☐ ABNORMAL:

CLIENT LAST NAME: FIRST: HCH#:

ASSESSMENT PLAN

ORDERS

- ❒ CBC / CBCD
- ❒ SMA 7/ 20
- ❒ LFT
- 0 AMYLASE
- 0 HIV
- 0 RPR
- 0 CD4
- ❒ VIRAL LOAD I USVL
- 0 TSH I TFT
- 0 HEPATITIS PROFILE
- ❒ HEP.BsAB
- ❒ CHOL / FASTING LIPDS
- 0 HBA1C
- 0 PSA
- 0 UA
- 0 URINE MICROALBUMIN
- 0 URINE DIPSTIX
- 0 BHCG
- 0 GC/CT I PAP SMEAR

- 0 PEFR
- 0 EKG
- 0 PPD
- ❒ OTHERS: _____

- 0 MEDICATIONS/INJECTIONS: _____

PATIENT EDUCATION

EDUCATED ON :

- ❒ ABLE TO VERBALIZE UNDERSTANDING
- ❒ ABLE TO RETURN DEMONSTRATION
- ❒ REFERED TO POET FOR FURTHER EDUCATION.

REFERRALS

- 0 CT SCAN _____
- ❒ ECHO
- 0 MRI _____
- 0 PFT
- 0 SONOGRAM _____
- 0 X-RAY _____
- 0 CASE MANAGEMENT
- 0 SOCIAL WORK
- 0 MENTAL HEALTH
- 0 ADDICTIONS COUNSELING
- 0 PODIATRY
- ❒ VISION VAN
- ❒ DIABETES CLASS
- 0 OTHERS: _____

RTC: NEXT DAY / WALK-IN / 1-2 WK
2-3 WK / 4-6 WK I 6-8 WK
IO-12 WK /

F/U VISIT TYPE: _____

PROVIDER (PRINT NAME: _____ PROVIDER SIGNA' I _____ DATE _____