Health Care for the Homeless
INFORMATION RESOURCE CENTER
888/429-3300 • Fax 518/439-7612

#11. HEALTH HISTORY

Adult health history (*WES 8*)
Adult screening history (*STL 2*)
Comprehensive pediatric history (*CAM 8*)
Drug history (*LOS 5*)
Family planning history/physical exam (*WES 9*)
Health assessment/history (*WAI 1*)
Health history (*MER 5*)
Health history for dental referrals (*BAL 34*)
Health questionnaire (*LOS 3*)
Historia Medica - Adult health history in Spanish (WES 8a)
History and physical form (*BAL 36*)
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Medical/dental history (*TRA 8*)
Medical history (*MON 12*)
Patient history (*COT 2*)
Patient history (*THU 1*)
Pediatric history (*HIP 1*)

WES 8

CONFIDENTIAL

MULTNOMAH COUNTY HEALTH DEPARTMENT

Adult Health History

DATE COMPLETED _____

PREVENTIVE CARE HISTORY

If you can not answer a question, leave it blank.

1. When was your last immunization for:

Tetanus (or Tetanus Diphtheria, Td).....Date_____ ☐ Don't know
Hepatitis B.....Date_____ ☐ Don't know
Hepatitis A.....Date_____ ☐ Don't know
Pneumococcal pneumonia.....Date_____ ☐ Don't know
Measles, mumps, rubella (MMR).....Date_____ ☐ Don't know
Flu (Influenza).....Date_____ ☐ Don't know

2. Do you now smoke? ..... ☐ Yes ☐ No
If yes, how much do you smoke? _____
Have you ever smoked? ..... ☐ Yes ☐ No
If you quit, Date? _____

Do you now chew tobacco? ☐ Yes ☐ No
If yes, how much do you chew? _____
Have you ever chewed tobacco? ..... ☐ Yes ☐ No
If you quit, Date? _____

3. Alcohol and Drug Use

Do you drink alcoholic beverages (beer, wine, wine coolers, liquor)? .... ☐ Yes ☐ No If yes, your age at first use _____.
How much do you drink in a week? _____
Do you ever drink more than 5 drinks in one sitting? ..... ☐ Yes ☐ No
Have you ever used street drugs (including marijuana)? ..... ☐ Yes ☐ No If yes, your age at first use _____.
If yes, what street drugs have you used? _____
When was the last time you used? Date _____ What did you use? _____.

4. Women's Health

When was your last Pap smear? Date _____
Have you ever had an abnormal Pap smear? ..... ☐ Yes ☐ No
When was your last mammogram (x-ray of breasts)? Date _____
Do you check your breasts for lumps? ☐ Yes ☐ No

5. Have you ever had a cholesterol test? ..... ☐ Yes ☐ No If yes, Date _____ Results _____

6. Have you ever been tested for HIV? ..... ☐ Yes ☐ No If yes, Date _____ Results _____

7. Have you ever had a skin test for tuberculosis (PPD)? ..... ☐ Yes ☐ No If yes, Date _____ Results _____

8. Have you ever had an examination of your colon or bowel (flexible sigmoidoscopy)? ..... ☐ Yes ☐ No If yes, Date _____

9. Which diseases listed below have your family members (mother, father, brothers, sisters) had:

diabetes _____ cancer _____
heart problems _____ high blood pressure _____
strokes _____ alcohol or drug abuse _____

PAST/CURRENT MEDICAL HISTORY

1. Do you have any major health problems? ..... ☐ Yes ☐ No If yes, please list: _____

_____
_____
_____

2. Are there any medicines you take regularly? ..... ☐ Yes ☐ No If yes, please list: _____

_____

3. Do you have any allergies to medicines? ..... ☐ Yes ☐ No If yes, what: _____

4. Have you ever stayed overnight in the hospital for any of the following problems?

Surgery ..... Date(s) _____ Where _____ Mental health .. Date(s) _____ Where _____
Alcohol or drug... Date(s) _____ Where _____ Medical ..... Date(s) _____ Where _____

_____
_____
_____
_____

CLIENT NAME _____ DATE OF BIRTH _____

STL 2

HEALTH CARE FOR THE HOMELESS PROGRAM
ADULT SCREENING HISTORY

AS8

Today's Date (___/___/____) Shelter: _____
M D Y

1. Name: _____ 2. Birthday: _____

3. Sex:..Male..Female 4. Race:..White..Black..Sp. Am...Other_____

5. Marital Status: _____ 6. Yrs of schooling: _____

7. Source of income: _____ 8. Monthly amount: _____

9. How long have you been without a regular place to live?_____

10. How many different times have you been homeless in your life?_____

11. Do you smoke?...Yes...No # per day_____

12. Do you currently drink alcohol?...Yes...No Amount per day_____

13. Has anyone ever told you that you have a drinking problem?....Yes...No
How long ago was that? _____

14. Do you currently take any medication or prescriptions?.....Yes...No
List Medications: _____

15. In the last 3 months have you taken street drugs?.....Yes...No
List Drugs: _____

16. Are you allergic to any medications?.....Yes...No
If yes, please list _____

17. Do you now have or have you ever had:

Diabetes.....Yes...No	High Blood Pressure.....Yes...No
Arthritis.....Yes...No	Yellow Jaundice.....Yes...No
Anemia.....Yes...No	Tuberculosis (or exposure)....Yes...No
Heart disease....Yes...No	Epilepsy (seizure disorder)...Yes...No
Lung disease.....Yes...No	Hearing trouble.....Yes...No
Kidney disease...Yes...No	Eyesight trouble.....Yes...No
Teeth Problems...Yes...No	Other:_____

18. Do you wear glasses?..Yes...No Should you wear glasses?..Yes...No

19. Have you been hospitalized for any reason within the last 5 years?
Yes...No If yes, why?_____

20. Have you been in a psychiatric hospital or institution within the last 5 years?..Yes...No If yes, how long ago?_____

21. Have you seen a mental health specialist within the last 5 years?
Yes...No

FOR WOMEN: L.M.P._____ Do you think you're pregnant...Yes...No

# of children delivered _____ # of children living _____

CAM 8

CAMILLUS HEALTH CONCERN, INC.
COMPREHENSIVE PEDIATRIC HISTORY

Last Name _____ First Name _____ Client # _____

Allergies: _____

1. Date	2. Name of Parent/Guardian	3. Care if Parent (s) Work/Away: Relative/Neighbor _____ Daycare _____ Hours/Day _____ Days/Week _____

4. Family History - Indicate relationship

Diabetes _____ Emotional illness _____ Birth defects _____
Lung disease/TB _____ Kidney/urinary disease _____ cancer _____
Mental retardation _____ Allergies/asthma _____ seizures _____
Heart disease/Stroke _____ Blood dyscrasias _____ hypertension _____
Substance abuse _____ other _____

5. Mother's Prenatal History

Conditions:
Hypertension _____ Rh _____ Alcohol amt. _____ OTC _____
Diabetes _____ X-ray _____ Tobacco amt. _____
S.T.D. (specify) _____ HbsAg _____ Prescription _____ Street drugs _____
Rubella _____ Other _____
Prenatal Care/Trimester begun: _____

6. Weeks gestation	Birth Weight	APGAR	Length	Head Circ.	Where delivered

7. Delivery History

SVD _____ Prolonged labor _____ Breech _____ PROM _____
Cesarean _____ Precipitous delivery _____ Forceps _____ Other _____

8. Neonatal Problems and Conditions

Deformities _____ Oxygen _____
Injuries _____ Irritability _____
Respiratory _____ Feeding _____
Cardiac _____ Incubator days _____
Jaundice _____ Tremors/seizure _____
Other (specify) _____

9. Infectious Disease/Date of Onset

Rubella _____ HIV _____
Measles _____ Hepatitis B _____
Pertussis _____ S.T.D. (specify) _____
Mumps _____
Chicken Pox _____ Other _____

10. Serious Illness, Accident, Hospitalization (s), Frequent Episodes of Minor Illness

Date: _____ Outcome: _____
Date: _____ Outcome: _____
Date: _____ Outcome: _____

_____
Signature/Title of Interviewer

LOS 5

Name _____ **DRUG HISTORY** Client I.D. # _____

Directions:

1. Check the "EVER" column for all drugs ever used and the "PREV. MONTH" column for those drugs used in the last month.
2. Enter 1, 2, and 3 in the "PROBLEM" column for the drug(s) the client believes to be the #1, #2, & #3 problem(s)
3. Complete the remaining columns for the problem drug(s) and all other clinically relevant drugs.

PROBLEM	DRUG	EVER	PREVIOUS MONTH	ROUTE: Oral smoked, inhaled, injected, other	DATE OF FIRST USE & LAST USE	PATTERNS OF USE (i.e. frequency, amounts, changes, dates of most recent run)
	HEROIN					
	NON-RX METHADONE					
	OTHER OPIATES & SYNTHETICS					
	ALCOHOL					
	BARBITURATES					
	OTHER SEDATIVE HYPNOTICS					
	AMPHETAMINES					
	COCAINE					
	MARIJUANA & HASHISH					
	HALLUCINOGENS					
	INHALANTS					
	OVER THE COUNTER					
	TRANQUILIZERS					
	PCP					
	OTHER (SPECIFY)					

[illegible] REVISED 9/91

LOS 5

)RUG HISTORY (contd.)

HAVE YOU EVER TRIED TO STOP USING? NO ___ YES ___ (# ___)

Comments (date, length, method) _____

_____

_____

_____

HAVE YOU EVER OVERDOSED? NO ___ YES ___ (# ___)

Comments (date, drug(s), emergency medical or other follow-up) _____

_____

_____

_____

HAVE YOU EVER BEEN IN A DETOX PROGRAM? NO ___ YES ___ (# ___)

Comments (date, program - *medical, methadone, or other*) _____

_____

_____

_____

HAVE YOU EVER BEEN IN A RESIDENTIAL OR SOBER LIVING PROGRAM?

NO ___ YES ___ (# ___)

Comments (dates, program) _____

_____

_____

_____

HAVE YOU EVER BEEN IN AN OUTPATIENT PROGRAM?

NO ___ YES ___ (# ___)

Comments (dates, program) _____

_____

_____

_____

WES 9

CONFIDENTIAL FAMILY PLANNING HISTORY

Adult Health History Form Must be Completed at Least Once

Current History (To be completed by client)

How old were you when your periods started?
(menstruation) _____

When was the 1st day of your last period? _____
Do you have bleeding between periods? Yes ___ No ___

What kind of birth control do you use now?

_____

What kind of birth control have you used before?

_____

Have you ever had your tubes tied? Yes ___ No ___

Have you ever had chicken pox? Yes ___ No ___

Have you ever had 3-day measles? Yes ___ No ___

Are you breastfeeding now? Yes ___ No ___

Obstetrical History:
- # pregnancies _____
- # live births _____
- # miscarriages _____
- # abortions _____

History to be taken by provider

Do you have any:
- vaginal discharge _____
- pain with urination _____
- pain with intercourse _____

1. Are you currently having sex with anyone?
   Yes _____ No _____

2. When was the last time you had sex? _____

3. # partners since last PAP smear. _____

4. Have your sex partners been men, women, or both? (circle one)

5. Have you ever had a sexually transmitted disease such as genital warts, herpes, chlamydia, gonorrhea, syphilis, or HIV?
   Yes ___ No ___ If yes, circle which one(s).

6. Have you ever been abused sexually or physically? Yes ___ No ___

If you were born before 1972 did your mother take DES when she was pregnant with you? Yes ___ No ___

CLIENT NAME _____
DATE OF BIRTH _____

FAMILY PLANNING PHYSICAL EXAM

**Minimal Title X Contraceptive Exam Requirements*

(To be completed by provider)

	N	Ab
*Thyroid Exam	_____	_____
**Breast Exam	_____	_____
Nodes	_____	_____
*Heart	_____	_____
*Lungs	_____	_____
*Peripheral veins	_____	_____
*Abdomen	_____	_____
**Genitalia:		
External	_____	_____
Vagina	_____	_____
Cervix	_____	_____
Uterus	_____	_____
Adnexa	_____	_____

** To be done at initial visit only.*
*** Annually if hormonal method of contraception.*

Significant physical findings (describe):

_____
_____
_____
_____
_____
_____
_____

LABS: *PAP ___ Preg Test ___
** Annually if IUD or hormonal method.*
GC ___ Hgb ___
CT ___ VDRL ___
UA ___ HIV ___

SEE PROGRESS NOTES FOR ASSESSMENT AND PLAN

EXAMINER : _____
DATE EXAMINED: _____

WAI 1-1

WAIKIKI HEALTH CENTER

HEALTH ASSESSMENT

DATE:__/__/_____

CLIENT NAME:_____ FILE # :_____

MALE:____ FEMALE:____ D.O.B:____/___/____ AGE:_____

ETHNIC BACKGROUND:_____

MARITAL STATUS: SINGLE_____ MARRIED_____ DIVORCED_____
SEPERATED_____ WIDOWED_____

MAJOR HOSPITALIZATIONS: write in your most recent hospitalizations for serious medical illnesses or operation, if any. Do not include normal pregnancies.

year	operation and/or illness	hosp./ city/state

HEALTH HISTORY: have you previously had, or do you presently have any of the following diseases?

___ anemia ___rheumatic fever ___ asthma/hayfever ___epilepsy

___ stroke ___venereal disease ___ diabetes ___liver disease/jaundice

___ ulcers ___high blood pressure ___tuberculosis/ ++skin test

___ gout ____lung trouble ___heart trouble ___ thyroid trouble

___ glaucoma ____cancer/tumor ____ bleeding tendency

other:_____

_____

Do you have medical insurance ? YES_____ NO_____
Name of insurance company _____

WAI 1-2

Name of Physician:_____

Location/phone #:_____

****

SUBSTANCE USE/ABUSE

ALCOHOL:_____ POLY SUBSTANCE:_____

What substances have you used (past/present) and how often:

_____

_____

_____

USUAL ROUTE(S) OF ADMINISTRATION: oral___ IV___ smoking___
inhalation___ skin pop___

Number of prior treatment experiences:_____

Do you smoke cigarettes? _____ How long? _____

If yes, how many per day:_____

****

Do you have any allergies:_____ If yes, please list and include common allergic reactions you have experienced with each allergie listed:_____

_____

_____

_____

Religious Preference? _____

****

NEXT OF KIN

Name: _____

Address:_____

Phone:_____

WAI 1-3

Date: _____

MENSTRUAL HISTORY

_____Age Period started

Periods are: ____ light

____regular ___painful ____moderate

____irregular ____heavy

Periods come every _____days.

Do you have bleeding between periods?

___YES ___NO _____ SOMETIMES

When was the first day of your last period? _____

Was it normal? ____YES ____NO

If you are sexually active, at what age you did you begin having intercourse?

_____

Do you have pain during intercourse?

____YES ____NO

Do you have bleeding during intercourse?

____YES ____NO

CONTRACEPTIVE HISTORY

Do you use a birth control method now?_____

If so, what methods do you use?

Give specific name, dose, size, type, etc.

List any problems with this method:_____

_____

What methods have you used in the past?

____pills: kind:

_____

_____diaphragm
_____foam, suppositories, cream, jellies
_____condoms
_____withdrawal or pulling-out
_____rhythm or calendar
_____mucus, basal temperature
_____I.U.D.
_____Sponge
_____None

List any problems with these past methods:_____

_____

_____

PREGNANCY HISTORY

_____total number of pregnancies
_____ age of first pregnancy
_____ do you desire pregnancy?

Number of:

_____abortions
_____miscarriages
_____still births
_____caesarians
_____ectopic (tubal) pregnancies
_____premature births
_____live births
_____living children

Complications or comments:

TO BE FILLED OUT BY NURSES OR DOCTORS:

_____ Alternatives for pregnant women
_____ Offered other services available at Waikiki Health Center
_____ AIDS risk reduction pamphlet.

HCG results
Positive + _____
Negative -_____

P:

Medications currently using: _____

_____

Have you ever been treated by a psychiatrist ? _____ If yes, what was the problem(s) ? _____

_____

Medications prescribed: _____

Diagnosis if known: _____

Name/address of Psychiatrist: _____

Family History: For your family members below, please indicate their present state of health with a "X" or write in the cause of death. Also indicate other pertinent family illnesses.

Relation	Age	Health		Cause of death	Anemia	Diabetes	Cancer or Tumor	Tuberculosis	High Blood Pressure	Kidney Trouble	Stroke	Heart Trouble
		Good	Poor									
Father												
Mother												
Sisters: No_____												
Brothers: No_____												
Children: Females												
Males												
Other Relatives:												

Other pertinent family illnesses: _____

_____

_____

_____

_____

WAI 1-5

VITAL SIGNS:

Blood pressure:_____ Pulse:_____

Height:_____ Weight:_____

****

SPOKEN HEALTH CONCERNS: Use the S.O.A.P. format to include immediate medical problems and/or lifestyle concerns:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

staff signature Date

MER 5

MERCY HOSPITAL/HEALTH CARE FOR THE HOMELESS

Health History

Date:_____

Client Name:_____ D.O.B:_____

S.S.#_____ Site:_____

PAST MEDICAL HISTORY:

ALLERGIES:

MEDICATIONS:

SUBSTANCE ABUSE:

Drug(s) of Choice:

Previous Tx:

Detox:_____

Long Term Tx:_____

Last Use:_____

Nicotine:_____

HOSPITALIZATIONS/OPERATIONS:

Last PPd:_____
Last Td:_____

HIV ASSESSMENT:

HIV Test (Y/N)_____

Risk Behaviors: (STD, IVDU, Sex)

HEALTH CARE PROVIDER

Last time seen:_____

MENTAL HEALTH HISTORY/TRAUMA,ABUSE:

OTHER SERVICES INVOLVED:

T_____ P_____ R_____ BP_____ Ht_____ Wt_____

FAMILY HISTORY: Heart Disease, DM, Hypertension, Substance Abuse, Mental Illness, Cancer, TB, HIV, Family Violence

SOCIAL HISTORY: Support System, Living Situation, Family Origin

REVIEW OF SYSTEMS

GENERAL: State of Health, Weight, Fatigue, Fever

SKIN: Rashes, Growths, Itching, Dryness, Sweating, Hair, Nails, Infection, Injury

HEAD: Headaches, Dizziness, Injury

EYES: Vision Blurring, Spots, Itching, Pain, Infection, Injury, Glaucoma, Glasses, Last Eye Exam

NOSE: Epistaxis, Allergies, Sinus Infections, Injury

MOUTH & THROAT: Teeth, Dental Exam, Sore Throats, Gum Condition, Injury, Infection

NECK: Pain, Stiffness, Injury, Nodes

CARDIOPULMONARY: Chest Pain, Dyspnea, Orthopnea, Palpitations, Cough, Sputum, Night Sweats, Edema, Wheezing, Hypertension, Infections, Trauma

G.I.: Appetite, Dysphagia, Nausea, Vomiting, Pain, Diarrhea, Rectal Bleeding, Constipation, Bowel Habits, Diet

G.U.: Dysuria, Polyuria, Urgency, Frequency, Kidney Stones, Urethral Discharge, Incontinence, Infections, Injuries, Sexual Activity/Problems/Orientation, STD's

MALE: Prostate, testicular self-exam

FEMALE: LMP, Menstrual Problems, Vaginal Bleeding, Discharge, Birth Control, Gravida/Para, Self-breast exam

MUSCULOSKELETAL: Muscle Pain, Cramps, Joint Pain/Swelling/Stiffness, Weakness, Numbness, Back Problems, Injuries

NEURO/PSYCH: Seizures, Loc, Balance, Paralysis, Tremor, Nervousness, Depression, Hallucinations, Motor/Sensory Loss, Therapy

HIV STATUS:

BAL 34

HEALTH CARE FOR THE HOMELESS, INC. ◆ 111 PARK AVENUE ◆ BALTIMORE, MD 21202 ◆ (410) 837-5533

HEALTH HISTORY FOR DENTAL REFERRALS

CLIENT NAME: _____ HCH#: _____

PROVIDER: _____ DATE: _____

HAS CLIENT HAD ANY OF THE FOLLOWING? INDICATE WITH A CHECK MARK (✓) OR X.
(EXPLAIN TREATMENT FOR ANY CONDITIONS PRESENT).

_____HEART PROBLEM
_____HEART MURMUR. IF YES, WAS CLIENT PROVIDED WITH SBE PROPHYLAXIS? _____
_____HIGH BLOOD PRESSURE
_____FAINTING OR DIZZINESS
_____CIRCULATORY PROBLEMS
_____ASTHMA
_____COPD OR OTHER PULMONARY CONDITION
_____ KIDNEY DISEASE
_____DIABETES
_____ARTHRITIS
_____EPILEPSY OR SEIZURES
_____SPEECH PROBLEMS
_____VISION OR EYE PROBLEMS
_____DEAFNESS OR HEARING PROBLEMS
_____USES WHEELCHAIR OR CRUTCHES
_____NEEDS ASSISTANCE TO WALK
_____SINUS PROBLEMS
_____PREGNANCY
_____SICKLE CELL DISEASE
_____EXCESSIVE BLEEDING

_____ HEPATITIS SIGNIFICANT BLOOD WORK RESULTS _____

_____ HIV IF NO, DATE OF LAST TEST _____
RISK FACTORS FOR HIV _____
(IF HIV+, SEND COPY OF CBC, CD4, CHEM, PT/PTT WITHIN PAST MONTH. REFER TO HIV CLINIC)

_____TUBERCULOS DATE OF LAST TB TEST OR CXR _____

_____SEXUALLY TRANSMITTED DISEASE

_____ALLERGY TO MEDICATION _____ALLERGY TO FOOD _____ALLERGY TO NOVACAINE OR NUMBING AGENT

PLEASE NOTE ANY ANTIBIOTIC AND/OR ANALGESIA PROVIDED TO CLIENT:

I AUTHORIZE RELEASE OF THE ABOVE INFORMATION TO THE DENTAL CLINIC. _____
(CLIENT SIGNATURE)

LOS 3

HOMELESS HEALTH CARE LOS ANGELES
HEALTH QUESTIONNAIRE

Name _____ Birthdate _____ Date _____

GENERAL MEDICAL HISTORY

1. Where do you go for health care?

___ Private Doctor
___ Free or Community or County Clinic
___ County Hospital
___ Other Hospital
___ HMO (Kaiser, Cigna, etc.)
___ Veterans Administration Medical
___ None
___ Other _____

2. When was your last physical exam? _____ dental exam? _____ tetanus shot? _____
Tuberculosis (TB) screening? _____ Results? _____

3. Do you have any of the following health problems?

	how long?		how long?		how long
diarrhea		fever		runny nose	
change in appetite		cough		breathing trouble	
itching		skin sores		light colored stool	
vomiting		rash		dark colored stool	
sore teeth		sore gums		yellow skin/eyes	
sore throat		tea-colored urine		teeth cavities	
sweat when asleep				difficulty sleeping	

other _____

4. Do you have any of the following chronic health problems?

Tuberculosis _____ High blood pressure _____ Seizures _____ Mental health problem _____
Asthma _____ Bronchitis _____ Vision problem _____ Hearing Problem _____
Heart problem _____ Kidney problem _____ Mental retardation _____ Anemia _____
Skin problem _____ Diabetes _____ Allergies (specify) _____
Other (specify) _____

5. Are you taking any medication? Yes ___ No ___
If yes list name of medication, reason dispensed, amount given _____

6. Have you been prescribed a medication and choose not to take it? Yes ___ No ___
If yes list name of medication and reason for not taking it _____

7. Have you been hospitalized in the last 6 months? Yes ___ No ___
If yes specify when, where, why, length _____

8. Have you ever been a victim of violence? Yes ___ No ___
If yes specify _____

DRUG HISTORY

9. Do you smoke cigarettes? Yes ___ No ___ If yes, # packs/cigarettes per day _____

DRUG HISTORY cont.

10. Have you ever used drugs or alcohol? Yes _____ No _____
If yes explain _____

11. Have you ever injected drugs? Yes _____ No _____ If yes, did you or do you?

Share needles	____all the time	____often	____some of the time	____rarely	____never
Clean needles	____all the time	____often	____some of the time	____rarely	____never
Bleach needles	____all the time	____often	____some of the time	____rarely	____never

SEXUAL HISTORY

12. Are you currently sexually active? Yes ____ No ____ If yes, what method of birth control are you and your partner(s) using?_____

13. How often are you and your partner(s) using condoms? Always ___ Often ___ Sometimes ___ Never ___

14. Sex of partners: Men ____ Women ____ Both ____

15. How many partners have you been with in the last 6 months?_____

16. Are any of your partner(s) known to be HIV positive or have AIDS? Yes ____ No ____

17. Have you ever exchanged sex for drugs or money? Yes ____ No ____

WOMEN'S HEALTH HISTORY

18. When was your Last Normal Menstrual Period? _____

19. When was your last pap smear? _____breast exam?_____

20. Pregnancy Status:
Pregnant ? Yes _____ No _____ Receiving prenatal care? Yes _____ No _____
Weeks gestation ____ EDC ____ Gravida (# pregnancies) ____ Parity (# live births) ____ # TAB (abortions) ____

FOLLOW UP NEEDS

General Medical
___physical
___TB screening
___tetanus booster
___dental evaluation

Drug History
___smoking cessation
___drug treatment program

Sexual History
___HIV info & education
___STD screening

Women's Health
___pap & breast screening
___family planning
___domestic violence
___pre-natal care
___pregnancy testing
___emergency precautions rev'd

NOTES

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
Staff Signature

WES 8a

CONFIDENTIAL

MULTNOMAH COUNTY
HEALTH DEPARTMENT

Historia Médica
Adult Health History

FECHA _____
Date completed

Favor de completar los dos lados
Fill Out Both Sides

CUIDADO PREVENTIVO
Si no conoce la respuesta a una pregunta, déjela en blanco.

PREVENTIVE CARE HISTORY
If you cannot answer a question, leave it blank

1. ¿Cuándo recibió las siguientes vacunas?
When was your last immunization?

Tétano (o Difteria Tétano, Td) ..... Fecha _____ ☐ No sé
Tetanus (or Tetanus Diptheria, Td) Date Don't know

Hepatitis B ..... Fecha _____ ☐ No sé

Hepatitis A ..... Fecha _____ ☐ No sé

Neumonía Bacteriana ..... Fecha _____ ☐ No sé
Pneumococcal pneumonia

Sarampión, Paperas, Rubéola (MMR) ..... Fecha _____ ☐ No sé
Measles, mumps, rubella (MMR)

Influenza ..... Fecha _____ ☐ No sé

2. ¿Usted fuma? ..... ☐ Sí ☐ No
Do you now smoke?

Si sí, ¿cuánto fuma? _____
If yes, how much do you smoke?

¿Ha fumado usted alguna vez? ..... ☐ Sí ☐ No
Have you ever smoked?

Si páro, ¿cuando? _____
Did you stop, when?

¿Mastica usted tabaco? ..... ☐ Sí ☐ No
Do you now chew tobacco?

Cuánto mastica _____
If yes, how much do you chew?

¿Ha masticado usted tabaco alguna vez? ..... ☐ Sí ☐ No
Have you ever chewed tobacco?

¿Si paró, ¿cuando? _____
Did you stop, when?

3. Uso de alcohol y drogas

¿Toma usted bebidas alcohólicas? (vino, cerveza, licor y refrescos de vino) ..... ☐ Sí ☐ No
Do you drink alcoholic beverages (beer, wine, wine coolers, liquor?)

Si sí, a qué edad empezó a tomar _____
If yes, your age at first use

Si sí, ¿cuánto toma por semana? _____
How much do you drink in a week?

Algunas veces, ¿toma usted más de cinco bebidas en cada ocasión? . ☐ Sí ☐ No
Do you ever drink more than 5 drinks in one sitting?

¿Ha usado usted alguna vez drogas incluyendo marihuana? ..... ☐ Sí ☐ No Si sí, a qué edad empezó a usar _____
Have you ever used street drugs (including marijuana)? If yes, your age at first use

¿Qué drogas ha usado? _____
What street drugs have you used?

¿Cuándo fue la última vez que las usó? Fecha _____ Qué usó _____
When was the last time you used? Date What did you use?

4. Salud de la mujer
Women's Health

¿Cuándo tuvo la última prueba de Papanicolaou? Fecha _____
When was your last Pap smear? Date

¿Tuvo usted alguna vez un resultado anormal? ☐ Sí ☐ No
Have you ever had an abnormal Pap smear?

¿Se examina usted sus senos para ver si tiene quistes? ☐ Sí ☐ No
Do you check your breasts for lumps?

¿Cuándo tuvo su último mamograma? (radiografía de los senos) Fecha _____
When was your last mammogram (x-ray of breasts)? Date

5. ¿Ha tenido usted alguna vez una prueba de colesterol? ..... ☐ Sí ☐ No Si sí: fecha _____ resultado _____
Have you ever had a cholesterol test?

NOMBRE DE CLIENTE _____ FECHA DE NACIMIENTO _____
Name Date of Birth

2548

MULTNOMAH COUNTY
HEALTH DEPARTMENT

Favor de completar los dos lados

Historia Médica

6. ¿Ha tenido usted alguna vez una prueba de VIH? ..... ☐ Sí ☐ No Si sí: fecha _____ resultado _____
Have you ever been tested for HIV?

7. ¿Ha tenido usted alguna vez una prueba de tuberculosis (PPD)? ..... ☐ Sí ☐ No Si sí: fecha _____ resultado _____
Have you ever had a skin test for tuberculosis (PPD)?

8. ¿Ha tenido usted alguna vez un examen de los intestinos?
(sigmoidoscopia flexible) ..... ☐ Sí ☐ No Si sí: fecha _____
Have you ever had an examination of your colon or bowel (flexible sigmoidoscopy)?

9. ¿Han tenido sus familiares alguna de estas enfermerdades?
Which diseases listed below have your family members had (mother, father, brothers, sisters)?

Diabetes _____ Cáncer _____

Enfermedad del corazón _____ Presión alta _____
Heart problems High blood pressure

Derrame o Apoplejía _____ Abuso del alcohol o las drogas _____
Strokes Alcohol or drug abuse

DATOS MÉDICOS EN EL PASADO O EN LA ACTUALIDAD.
Past\Current Medical History

1. ¿Tiene usted algún problema grave de salud ? ..... ☐ Sí ☐ No Si sí, indique cuál: _____
Do you have any major health problems? If yes, please list

_____

_____

2. ¿Alguna vez, ha sido internado en el hospital por alguno de estos problemas:?
Have you ever stayed overnight in the hospital for any of the following problems?

Cirugía ..... Fecha _____ ¿Donde? _____ Problema de salud mental .. Fecha _____ ¿Donde? _____
Surgery Where Mental health Where

Alcohol o drogas .. Fecha _____ ¿Donde? _____ Otra Enfermedad ..... Fecha _____ ¿Donde? _____
Alcohol or drug Medical

3. ¿Toma usted alguna medicina diariamente? ..... ☐ Sí ☐ No Si sí, indique cuáles: _____
Are there any medicines you take regularly? If yes, please list

_____

_____

4. ¿Tiene usted alergia a alguna medicina? ..... ☐ Sí ☐ No Si sí, indique a cuál: _____
Do you have any allergies to medicines? If yes, what:

_____

NOMBRE DE CLIENTE _____
Name

BAL 36-1

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: Pain Score (check one): (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

REVIEW OF SYSTEMS (check, if present):

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

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

	Yes	No	Year Dx
Anemia			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney/Bladder Problem			
Lung Disease			
Seizures			
Skin Disorders			
Stomach/Gastrointestinal Problems			
Stroke			
Thyroid Disease			
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-Prescriptions) 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 given?			

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 ☐Past 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 **Tobacco**? ☐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 condr ☐No ☐Yes ☐Sometimes

BAL 36-2

HISTORY AND PHYSICAL FORM

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: Mouth - lips pink and symmetrical; dentition good; oral mucosa pink and moist; tongue moist, no ulcer. Ears; no scars, lesion, or 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 deformity; 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, no palpable masses, non-tender; Adnexiae - normal 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:

ASSESSMENT PLAN

ORDERS

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

- ☐ PEFR
- ☐ EKG
- ☐ PPD
- ☐ OTHERS: _____

- ☐ MEDICATIONS/INJECTIONS: _____

_____

_____

_____

_____

_____

PATIENT EDUCATION
EDUCATED ON :

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

REFERRALS

- ☐ CT SCAN_____
- ☐ ECHO
- ☐ MRI_____
- ☐ PFT
- ☐ SONOGRAM _____
- ☐ X-RAY_____
- ☐ CASE MANAGEMENT
- ☐ SOCIAL WORK
- ☐ MENTAL HEALTH
- ☐ ADDICTIONS COUNSELING
- ☐ PODIATRY
- ☐ VISION VAN
- ☐ DIABETES CLASS
- ☐ OTHERS: _____

RTC: NEXT DAY / WALK-IN / 1-2 WK
2-3 WK / 4-6 WK / 6-8 WK
10-12 WK /

F/U VISIT TYPE: _____

PROVIDER (PRINT NAME) _____ PROVIDER SIGNATURE _____ DATE _____

DAL 67

.EALTH CARE FOR THE HOMELESS. INC.
HISTORY AND PHYSICAL FORM

DATE: _____

CLIENT NAME: _____ HCH NUMBER: _____

DATE OF BIRTH: _____ GENDER: _____

CHIEF COMPLAINT: _____

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

I. PATIENT'S USUAL SOURCE OF HEALTH CARE _____

II. PERCEIVED STATE OF HEALTH? HOW WOULD YOU DESCRIBE YOUR HEALTH? _____

III. **MEDICAL PROBLEMS:** DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? (CHECK NEXT TO ANSWER)

HIGH BLOOD PRESSURE	YES[ ]	NO[ ]	YR. DX._____
HEART DISEASE	YES[ ]	NO[ ]	YR. DX._____
LUNG DISEASE	YES[ ]	NO[ ]	YR. DX._____
DIABETES	YES[ ]	NO[ ]	YR. DX._____
ANEMIA	YES[ ]	NO[ ]	YR. DX._____
THYROID DISEASE	YES[ ]	NO[ ]	YR. DX._____
STROKE	YES[ ]	NO[ ]	YR. DX._____
CANCER	YES[ ]	NO[ ]	YR. DX._____
"NERVE PROBLEMS" OR PSYCHIATRIC PROBLEM (INCLUDING DEPRESSION)	YES[ ]	NO[ ]	YR. DX._____
ARTHRITIS	YES[ ]	NO[ ]	YR. DX._____
GASTROINTESTINAL (STOMACH) PROBLEMS	YES[ ]	NO[ ]	YR. DX._____
GENITO-URINARY (KIDNEY OR BLADDER) PROBLEMS	YES[ ]	NO[ ]	YR. DX._____
SKIN DISORDERS	YES[ ]	NO[ ]	YR. DX._____
SEIZURES	YES[ ]	NO[ ]	YR. DX._____
ANY OTHER MEDICAL DIAGNOSIS WE HAVEN'T COVERED? (LIST)	YES[ ]	NO[ ]	YR. DX._____

IV. **OB/GYN**

		YES	NO	COMMENTS
A.	HAS THE PATIENT EVER BEEN PREGNANT	[ ]	[ ]	
B.	IF YES, HOW MANY: FULL-TERM PREGNANCIES:	_____		
	PREMATURE BIRTHS	_____		
	MISCARRIAGES OR ABORTIONS	_____		
	LIVING CHILDREN	_____		
C.	BEGINNING DATE OF LAST MENSTRUAL PERIOD	__/__/__		
D.	WAS LAST MENSTRUAL PERIOD NORMAL?	[ ]	[ ]	
E.	DOES THE PATIENT USE A BIRTH CONTROL METHOD	[ ]	[ ]	
F.	IF YES, SPECIFY			
G.	WHEN WAS LAST PAP TEST?	__/__/__		

V. **PREVIOUS HOSPITALIZATIONS/SURGERIES/INJURIES**

DATE	PROBLEM	PLACE

VI. VACCINATION HISTORY

		YES	NO	
A,	MEASLES, MUMPS, RUBELLA (MMR)	[ ]	[ ]	
B.	LAST TETANUS BOOSTER	[ ]	[ ]	__/__/__
C.	HEPATITIS B	[ ]	[ ]	
D.	PNEUMOVAX	[ ]	[ ]	

VII. TUBERCULOSIS HISTORY

		YES	NO
A,	ANY KNOWN EXPOSURE TO M.Tb?	[ ]	[ ]
B.	DATE OF LAST PPD	__/__/__	
C.	ANY HISTORY OF POSITIVE PPD?	[ ]	[ ]
D.	IF YES, WAS PROPHYLAXIS GIVEN?	[ ]	[ ]
E.	IF YES, DURATION AND TYPE	_____	

VIII. FAMILY HISTORY

		YES	NO	
A,	BLEEDING TENDENCY	[ ]	[ ]	_____
B.	CANCER (TYPE)	[ ]	[ ]	_____
C.	DIABETES	[ ]	[ ]	_____
D.	HEART DISEASE	[ ]	[ ]	_____
E.	HIGH BLOOD PRESSURE	[ ]	[ ]	_____
F.	SUICIDE, MENTAL ILLNESS	[ ]	[ ]	_____
G.	STROKE	[ ]	[ ]	_____

IX. HIV HISTORY

A. HIV TEST: DATE AND LAST RESULT:_____

B. LAST CD4_____ DATE DIAGNOSED __/__/__

C. HOW CONTRACTED:_____

X. MEDICATIONS (PRESCRIPTIONS & NON-PRESCRIPTION) INCLUDE NAME, DOSAGE & FREQUENCY:

1.	5.
2.	6.
3.	7.
4.	8.

XI. ALLERGIES (Describe Symptoms): _____

XII. HABITS AND LIFESTYLE

1. WHERE DO YOU EAT MEALS?_____ DO YOU HAVE ACCESS AND RESOURCES TO OBTAIN AN ADEQUATE SUPPLY OF FOOD? [ ] YES [ ]NO IF YES, WHAT RESOURCES:_____
2. WHAT IS YOUR CURRENT LIVING SITUATION (PARENTS, FRIENDS, SQUAT, STREET, FOSTER HOME SCHOOL, ETC.)?_____
3. ANY RECENT LIFE CHANGES (DIVORCED, MOVED, DEATH, ETC.)? _____
4. DO YOU TAKE DRUGS? [ ] YES [ ]NO IF YES, PLEASE LIST: _____
   _____
   IF YOU TAKE DRUGS, HOW DO YOU TAKE THEM (SNORT, SHOOT UP, SKIN POP, SMOKE, POP, ETC.)?_____
   _____ DO YOU SHARE NEEDLES?_____
5. DO YOU DRINK ALCOHOL? [ ] YES [ ]NO IF YES, NUMBER OF DRINKS PER DAY:_____ PER WEEK:_____
   IF NO, WHEN DID YOU QUIT? _____
   HAVE YOU EVER HAD A BLACKOUT WHILE DRUNK OR HIGH? (HAVE YOU DONE THINGS THAT YOU DON'T REMEMBER DOING)? [ ] YES [ ] NO
   DO YOU SMOKE/CHEW TOBACCO? [ ] YES [ ]NO IF YES, HOW LONG _____HOW MANY CIGARETTES A DAY:____ # OF YRS.____
   HAVE YOU EVER SMOKED? [ ] YES [ ]NO IF YES, HOW LONG_____. WHEN DID YOU QUIT?_____
6. SEXUALLY TRANSMITTED DISEASES? [ ] YES[ ]NO WHAT DIAGNOSIS:_____
   HOW, WHEN, WHERE TREATED: _____
   CLIENT'S SEXUAL ORIENTATION:_____
   HOW MANY PARTNERS HAS CLIENT HAD IN PAST YEAR?_____ DOES CLIENT USE CONDOMS? [ ] YES [ ]NO
7. HAS ANYONE EVER TOUCHED YOU IN A WAY THAT WAS FRIGHTENING, PAINFUL, OR MADE YOU FEEL UNCOMFORTABLE? [ ]YES [ ] NO
   _____
   WHAT HAPPENS WHEN YOU ARGUE WITH YOUR PARTNER?_____
8. IS THERE SOMETHING YOU NEED SUPPORT WITH OR A REFERRAL FOR? [ ] YES [ ]NO IF YES, SPECIFY:_____
   _____

XIII. REVIEW OF SYSTEMS (CHECK, IF POSITIVE)

☐DIZZINESS_____	☐ABDOMINAL PAIN_____	☐BLOOD IN URINE_____
☐HEADACHES PAIN_____	☐DIARRHEA/CONSTIPATION_____	☐DIFFICULT ERECTION_____
☐NUMBNESS/WEAKNESS_____	☐BLACK STOOLS_____	☐DISCHARGE FROM VAGINA/PENIS_____
☐VISUAL PROBLEMS _____	☐RECTAL BLEEDING_____	_____
☐HOARSENESS/COUGH_____	☐WEIGHT LOSS_____	☐RASH,SORE,ITCHING_____
☐SHORTNESS OF BREATH_____	☐PAINFUL/DIFFICULTY URINATION_____	☐PAINFUL JOINTS_____
☐CHEST PAINS_____	☐EXCESSIVE URINE_____	☐SWOLLEN ANKLES_____
☐PALPITATIONS_____	☐EXCESSIVE THIRST_____	

_____ INTERVIEWER SIGNATURE

_____ INTERVIEWER NAME

_____ DATE

AL 6-2

NAME:_____ HCH #:_____ DATE:_____

TEMP_____ PULSE _____ R_____ BP_____

WEIGHT_____ HEIGHT_____ CONTACT_____

GENERAL APPEARANCE:

HEAD: _____

EYES/FUNDI: _____

EARS/NOSE: _____

ADENOPATHY: _____

OROPHARNYX: _____

NECK: _____

HEART: _____

_____

LUNGS: _____

_____

BREASTS: _____

ABDOMEN: _____

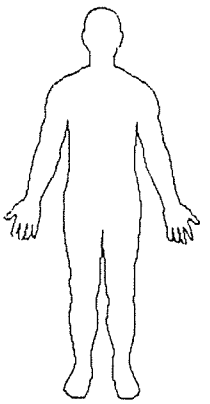
_____

RECTAL/PROSTATE: _____

GENITALIA/PELVIC: _____

EXTREMITIES: _____

PULSES: _____



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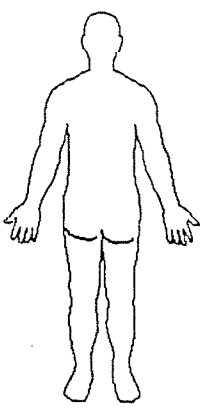


(POST)

NEURO: _____ DTR'S:

MMSE: _____

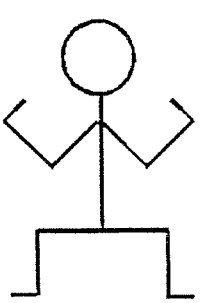
CN: _____

MOTOR: _____

SENSATION: _____

CEREBELLAR: _____

GAIT: _____



SKIN: _____

ASSESS/PLAN: _____

ORDERS:

CBC	☐	X Ray.....		**REFERRALS:**	
SMA 7/20	☐	CT Scan.....		Case Management/SW	☐
LFT	☐	Sonogram.....		Mental Health	☐
Amylase	☐	MRI.....		Addictions Counselor	☐
HIV	☐	EKG	☐	Vision Van	☐
RPR	☐	Echo	☐	Diabetes Class	☐
CD4	☐	PFT	☐	Groups.....	
Viral Load	☐	PEFR	☐	Provide Education on	
TSH	☐	Others.....		.....	
Hepatitis profile	☐	.....		**Outside Referral to:**	
HepC	☐	.....		.....	
UA	☐	.....		.....	
		PPD	☐	.....	

RTC.....

Medications/Injections.....

.....

PROVIDER SIGNATURE | DATE | PRINT NAME

BAL 6-11

TKA 8

TRAVELERS AID SOCIETY OF RI
177 UNION STREET
PROVIDENCE, RI 02903

REVIEWED BY_____DATE_____
REVIEWED BY_____DATE_____
REVIEWED BY_____DATE_____
REVIEWED BY_____DATE_____

MEDICAL/DENTAL HISTORY

PATIENT NAME:_____ TODAY'S DATE:_____
Last First Middle Initial Mo. Day Year

The following information is considered confidential medical information. It may be necessary to share this with your case worker in order to coordinate services.

If Yes, Explain

Answer the following questions by circling Y(Yes) or N(No) to which ever applies:

Have you been hospitalized or had any serious illness? . . . . . Y N
Has there been any changes in your general health within the past year? . . . . . Y N
Do you have allergies or bad reactions to any medications, prescription, or over the counter? . . . . . Y N
If yes, list_____
Do you take or apply any medicine (including birth control pills)? . . . . . Y N
If yes, list (including over the counter)_____

Do you have a physician? Y N Name:_____
Address:_____
Date of last physical: Mo. Yr. Place of exam:_____

Do you have a dentist? Y N Name:_____
Address:_____
Date of last dental exam: Mo. Yr. Last dental X-rays:_____
FEMALES ONLY: Are you pregnant, or do you suspect you may be? Y N Due date:_____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?:

MEDICAL		EXPLAIN			EXPLAIN
Rheumatic Fever	Y N		Blood Transfusion	Y N	
Heart Murmur	Y N		Blood Refused for Donation	Y N	
Valve Disorder(heart) or Surgery	Y N		Bleeding Disorder, i.e. Hemophilia	Y N	
Artificial Joint Replacement	Y N		Benign Tumor or Cancer	Y N	
Sugar Diabetes	Y N		Radiation Therapy	Y N	
Yellow Skin or Eyes	Y N		Breathing difficulties	Y N	
Hepatitis	Y N		Heartburn, Stomach disorders	Y N	
Tuberculosis	Y N		Hearing problems	Y N	
High/Low Blood Pressure	Y N		Eye problems	Y N	
Kidney Problems	Y N		Sexually Transmitted Disease	Y N	
Seizures, Epilepsy	Y N		Last treated_____		
Thyroid Disorder	Y N		Intimate contact with anyone at risk for AIDS	Y N	
Heart Trouble, Surgery, Angina, etc.	Y N		IV Drug User	Y N	
Pacemaker	Y N		Multiple Sex Partners	Y N	
Stroke	Y N		Intimate contact with bisexuals	Y N	
Drug Abuse problem	Y N		Emotional problems	Y N	
Alcohol Problem	Y N		Received treatment for emotional problem	Y N	
Treatment for Substance Abuse	Y N		If so, where?_____		
Do you smoke? # of packs/day___	Y N				

DENTAL		EXPLAIN			EXPLAIN
Do you have pain?	Y N		Do you brush your teeth?	Y N	
If yes, where?_____			If so, how often?_____		
Is the pain constant?	Y N		Do you need a tooth brush, tooth paste, floss?	Y N	
Is the pain associated with hot/cold or sweets?	Y N		Do you floss?	Y N	
Do you take something for the pain?	Y N		Do you know how to floss?	Y N	
If yes, what?_____			Do your gums bleed?	Y N	
Is there anything unusual about your mouth?	Y N		If yes, when?_____		
Tooth pulled?	Y N		Root canal therapy?	Y N	
Fillings?	Y N		Do you have any questions?	Y N	
Removable teeth?	Y N				
Bad experiences with previous dental treatment?	Y N				
If so, explain_____					

I have answered the above questions honestly and hereby grant permission to administer dental care to: Travelers Aid Society of RI 177 Union Street, Providence, RI 02903.

Signature of Patient:_____ Date:_____

Signature of Responsible Adult if Under 16:_____

MON 12

MONTEFIORE

New York Children's Health Project
Division of Community Pediatrics

Name: *Last* *First*

MR #: 900 – ____ ____ – ____ ____ – ____ ____

MEDICAL HISTORY

DATE

BEFORE ENTERING THE SHELTER SYSTEM, DID YOU HAVE A PARTICULAR PLACE WHERE YOU TOOK YOUR CHILD FOR ROUTINE CHECK UPS AND IMMUNIZATIONS? (2)

☐ Yes ☐ No

SOMETIMES PEOPLE CAN'T GET THEIR CHILD TO A MEDICAL PROVIDER AS SOON AS THEY'D LIKE TO. HAS THIS EVER HAPPENED TO YOU? (3)

☐ Yes ☐ No

WHERE DO YOU TAKE YOUR CHILD FOR ROUTINE CHECK-UPS AND IMMUNIZATIONS? (1)

☐ Hospital Clinic (hc) ☐ Public Clinic - DOH (pu)
☐ Health Center (hc) ☐ No Provider (no)
☐ Multiple Providers (mp) ☐ Private M.D. (md)
☐ Private Clinic (pc) ☐ Hospital E.R. (er)

WHAT, IF ANY, IS THE MAIN REASON WHY YOU COULDN'T GET TO YOUR REGULAR HEALTH CARE PROVIDER? (4)

☐ Couldn't Get Appointment (ap) ☐ No Transportation (tr)
☐ Problems Health Insurance (pi) ☐ Cost Too Much (ct)
☐ No Baby-Sitter Children (nb) ☐ Didn't Know Where To Go
☐ Not a Problem (no) ☐ Other: (ot) _____

Previous Provider:

	NAME	Date of Birth	SIBLING'S NAMES	Date of Birth
Mother				
Father				
Sibling				

PERINATAL HX: (0-1 Year) **Birth Weight:** ____ Lbs. ____ Ozs. **Gestation:** ____ Weeks **Delivery:** ☐ NSVD ☐ C/S

Complications: ☐ Yes ☐ No **If Yes, Age at Discharge:** ____ Days ____ Weeks **Hospital:**

If Yes, Describe:

MATERNAL HX: **Tobacco:** ☐ Yes ☐ No **ETOH:** ☐ Yes ☐ No **Drugs:** ☐ Yes ☐ No

Time Since Patient's Last Check-Up? _____ Months _____ Years ☐ Never

PMH	Yes	No	DESCRIBE	Add To Problem List?
Prior Hospitalization				
Surgeries				
Medical Problems				
Current Medications				
Allergies				
Accidents (Injuries)				

FAMILY HX	Yes	No	RELATION		Yes	No	RELATION
Heart Disease				Cancer			
Hypertension				Asthma / Allergy			
High Cholesterol				TB			
Psych / Mental				Blood Disease			
Neuro / Seizures				Diabetes			

Other Environmental / Social Health Concerns: ☐ Lead ☐ HIV ☐ Drug / Alcohol ☐ Domestic Violence ☐ CWA

W/C ( ) Yes ( ) No ( ) NE Foodstamps ( ) Yes ( ) No ( ) NE Suff. Food Resources ( ) Yes ( ) No

SIGNATURE:

S & S, INC. 72418 (5/95)

COT 2

Charter Oak Terrace-Rice Heights Health Center, Inc.

HOMELESS HEALTH CARE

Shelter Site: _____ Social Security # _____

Patient's Name: _____ Marital Status: ☐ S ☐ M ☐ D ☐ Se ☐ W

D.O.B. _____ Age _____ Family Status: ☐ Single 20+

Sex: _____ Ethnicity: (B) (W) (H) (A) (O) (U) ☐ Unattached<19-

Insurance: _____ Income: _____ ☐ 20+ in Family

☐ Food Stamps ☐ WIC ☐ 0-19 in Family

Education: ☐ E ☐ HS ☐ College _____ ☐ Head of Household 15-19

☐ Unknown

Housing: ☐ Shelter ☐ Trans. ☐ Street ☐ Double ☐ Other ☐ Unknown

Presenting Problem: _____

_____

Vital Signs: BP _____ HR _____ RESP _____ TEMP _____ WEIGHT _____

PMH

Last physical exam, where: _____

Illness: _____

Hospitalizations: _____

Allergies: _____

Obstetric HX: Pregnancies _____ Abortions _____ LMP _____

Family Health HX: _____

Current Medications: _____

_____

Tobacco: ☐ ETOH ☐ Drugs ☐

HIV ☐ Date: _____ PPD ☐ Date: _____ Tetanus ☐ Date: _____

SYSTEMS REVIEW

1. Skin: open wounds, rashes, color
2. Respiratory: pattern _____ rate _____ cough, chest pain, SOB
3. CV: rate _____ rhythm _____ BP _____
4. Urinary: color, odor, pain/burning, frequency, discharge, incontinence, flank pain, chemstix
5. Reproductive: breasts-tenderness, discharge, lumps menstruation, genital inflammation, pain, discharge
6. Neurologic/Psych: orientation, behavior, seizures
7. Musculoskeletal: ROM, arthritis, pain, spasms tingling, cramping, numbness
8. Heent: headache, dizziness, ear pain, sore throat, eyesight, eye inflammation, nasal/sinus congestion,
9. GI: teeth, gums, appetite, bowel habits, bowel sounds, stool color, occult blood, distention, N/V, pain

_____ RN

NOTES

DATE _____

THU 1

Thundermist Health Associates
Patient History

Date_____ Med. Rec. #_____ Worker_____

Name_____Age_____DOB_____

Site: Shelter Kitchen_____ Haven Sojourner Tri-Hab King

Length of stay_____Reason came to site_____

_____

Presently working? Y N Last job_____Year_____

Highest grade completed_____Veteran? Y N Discharge_____

Reason for visit_____

Other medical/social concerns_____

_____

Past Medical Hx:

Surgeries_____

Injuries_____

Illnesses requiring hospitalization or medication for long period_____

_____

Current meds_____

Allergies_____Last dental exam_____

Last eye exam_____Last TB test_____Last tetanus_____

Family Hx:

p/m gm p/m gf m f s b c
(note grandmother, grandfather, mother, father, sister, brother, child)

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

diabetes heart disease/stroke cancer sickle cell/thalessemia

epilepsy kidney disease high blood pressure birth defects

alcoholism/substance abuse

Habits:

	substance used	how much	how often	time using	time since use
Smoking					
Alcohol					
Drugs					

Mental Health Hx:

Ever seen a counselor for help?_____

Ever been in psych hospital?_____dates/length of stay_____

_____

Meds prescribed?_____

Suicide attempts (when, how, changes since)_____

_____

Ever been in drug or alcohol rehab?_____dates/length of stay_____

_____

Any physical or sexual abuse?_____

Sexual hx:

#Partners in last year?_____ Condom/foam use_____

Any STD's?_____

Know sexual hx of partners?_____

HIV contact_____

Hepatitis contact_____

Female: LMP_____ #Pregnancies_____

Last PAP_____ #Live births_____

Last mammogram_____ #Miscarriages_____#Ab's_____

Breast self-exam_____

#Children_____ Live w/ patient?_____

Ages_____

Intaké completed by_____ 6/93

HIP 1

HOMELESS INITIATIVE PROGRAM

Pediatric History Form

NOTES:

NAME: _____ Birth date: ___/___/___ Today's Date: ___/___/___

Mother's Name: _____ Father's Name: _____

FAMILY HISTORY

Tb_____ CVA _____ Heart Trouble: _____ Htn: _____

Epilepsy _____ HIV:_____ DM:_____ MI _____

Kidney Disease: _____ CA: _____ Hepatitis B orC_____

Sickle cell disease/trait: _____ Asthma: _____ Allergy:_____

ETOH Abuse: _____ Substance Abuse: _____

Learning problems: _____ Other: _____

_____

_____

_____

Do any family members smoke: _____

PAST MEDICAL HISTORY

Preg. prob.:_____ RX/ETOH/Drugs: _____

_____ _____

_____ _____

_____ _____

Mother's age at delivery: _____ Del Type: _____

L&D prob.: _____

Length of Labor: _____ Gest. age: _____ Nursery: _____

Birth weight: _____ Birth Length: _____ How long til d/c: _____ d/c wght:_____

Problems with baby: _____

_____

_____

Illnesses

Chicken Pox	Strep Throat/scarletina	Fx
Asthma	Rheumatic Heart Disease	Measles
Mumps	Rubella	DM
Sickle cell tr/dis	Pneumonia	Pertussis
Meningitis	Epilepsy	

Other: _____

_____

Hospitalizations

Date	Reason	Location

Social Hx

Who lives with pt.: _____

_____

Location and custody of other siblings: _____

_____

Past living arrangements: _____

_____

NOTES

Accidents: _____

Allergies: _____ Current Meds: _____

Seat Belts: Brushes Teeth Seen a Dentist
City Water Well Water

DEVELOPMENT

Age of 1st wd.:_____ Toilet Training: _____
Feeds: _____
Fine Motor: _____
Gross Motor: _____

NUTRITION

WIC_____ Vit/Sup: _____ Appetite: _____
24 Hr. Diet: _____

Habits: _____ Sleep: _____

Past Care Provider Location

IMMUNIZATIONS

Vaccine	Dose	Date of most recent	Vaccine	Dose	Date most recnt	Vaccine	Dose	Date mst rcnt
__ **DPT**	# 1 2 3 4 5	_____	__ DT (Peds)		_____	__ DTaP/Hib	1 2 3 4	_____ *
__ **Hib**	# 1 2 3 4.	_____	__ Hep B	# 1 2 3.	_____	__ IPV	1 2	_____ **
__ **OPV**	# 1 2 3 4 5	_____	__ DTaP		_____	__ Varicella		_____ ***
__ **MMR**	# 1 2	_____	__ Influenza		_____	__ Other_____		_____
__ **TB skin Test (PPD)**		_____						

* New in 1997 ** MCHD rec. IPV 1 & 2 for newborns then OPV
*** HIP doesn't give; refer to MCHD clinics if interested

OTHER _____

Interviewer: _____ Date: _____