## HEALTH SCREENING
(H) Rev. 09-09

Lake County Health Department
and Community Health Center
Behavioral Health Services

| CLIENT'S NAME: | D.O.B: |
|---|---|

Name of person filling out this form, if different from client:

Please answer the following questions to the best of your ability. Your counselor will discuss this with you.

### PHYSICAL HEALTH SCREENING

**DO NOT IDENTIFY HIV OR AIDS ON THIS OR THE FOLLOWING PAGE**

(Check the appropriate response)

| | Yes | | No | Are you currently under the care of a doctor? |
|---|---|---|---|---|

| If yes, what is the doctor's name? | Date of last visit? |
|---|---|

Doctor's address:

What is/are the medical problem(s)/current physical symptoms? ______________________________

What is the treatment? ______________________________

Any medical problems you want addressed during treatment? ______________________________

| | Yes | | No | Do you take any over-the-counter medications (including herbal, alternative, vitamins, etc.) on a regular basis? |
|---|---|---|---|---|

If yes, please list them and the reason: ______________________________

| | Yes | | No | Do you take any medication at this time, including birth control, either prescribed for you or for someone else? |
|---|---|---|---|---|

If yes, please list the medication(s) and the reason(s): ______________________________

Have you ever had any of The following conditions? (check those that apply to you.)

| | Condition | | Condition |
|---|---|---|---|
| | Diabetes (sugar) | | Sickle cell anemia or trait |
| | Hypertension (high blood pressure) | | Shortness of breath/Asthma |
| | Pneumonia/Respiratory/Bronchitis | | Kidney/Bladder/UTI |
| | Heart Problems | | Numbness in legs, arms, hands and feet |
| | Hepatitis/Jaundice (liver problems) | | Gastritis (upset stomach)/Ulcers |
| | Pancreatitis | | Sexually transmitted disease |
| | Arthritis/Lupus | | Esophageal Varicies (vomiting blood) |
| | Thyroid problems | | STD Test – If yes, date of test: |
| | Tuberculosis - If yes, date of last treatment: | | |
| | Other; what? | | |

| | Yes | | No | Question |
|---|---|---|---|---|
| | Yes | | No | Do you have any physical limitations or disabilities? If Yes, please explain: |
| | Yes | | No | Have you had any past injuries/trauma/accidents (including physical/sexual abuse)? If Yes, please explain: |
| | Yes | | No | Have you ever been hospitalized for a *medical* reason or had surgery? If Yes, please explain: |
| | Yes | | No | Do you have any food or drug allergies? If Yes, what are they? |

| Date you last used any alcohol: | Date when you last used any drugs: |
|---|---|

Please name the drugs you used:

## NUTRITIONAL SCREENING

| | | | | |
|---|---|---|---|---|
| | Yes | | No | *Do you have any nutritional problems or concerns? |
| | | | | If Yes, what are they? |

| | |
|---|---|
| WHAT IS YOUR CURRENT HEIGHT? | WHAT IS YOUR CURRENT WEIGHT? |

| | | | | |
|---|---|---|---|---|
| | Yes | | No | Have you lost or gained weight in the last month? |
| | | | | If Yes, how much? **(if greater gain than 10 pounds or greater loss than 8 pounds)** |
| | Yes | | No | Do you take medications that may affect your weight or nutrition? |
| | | | | If Yes, what medications? |
| | Yes | | No | Are you on a special diet? |
| | | | | If Yes, for what? |
| | Yes | | No | Do you follow it? |
| | Yes | | No | Do you vomit to lose or control your weight? |
| | Yes | | No | Do you ever binge eat, or eat nonstop throughout the day, or have any other eating problem? |
| | Yes | | No | Do you use ever use excessive exercise, laxatives, or diuretics to lose or control your weight? |

## ORAL HEALTH SCREENING

| | | |
|---|---|---|
| Date of last visit to the dentist: | Name of Dentist: | Location: |

| | | | | |
|---|---|---|---|---|
| | Yes | | No | Are you currently experiencing any dental or oral health problems/pain? |

If “yes,” please explain and list any care you are receiving:

## PAIN MANAGEMENT SCREENING

| | | | | |
|---|---|---|---|---|
| Are you experiencing any pain? | | No | | Yes, describe what and where: |
| Any history of chronic pain? | | No | | Yes, explain: |

What, if any, treatment do you receive for your pain?

| | | | | |
|---|---|---|---|---|
| Do you have Advanced Directives for medical or psychiatric care? | | No | | Yes |
| Do you want information on obtaining Advanced Directives? | | No | | Yes |

## WOMEN ONLY

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Yes | | No | Are you pregnant at this time? | | Yes | | No | Was your last pap smear abnormal? |

| | |
|---|---|
| **CLIENT/GUARDIAN SIGNATURE:** | **DATE:** |

### *FOR OFFICE USE ONLY*

### CLINICIAN OR RN REVIEW

**(Check all that apply and refer any checks to a program physician for assessment)**

| | | |
|---|---|---|
| Medical: | | Any diagnosis/condition with no medical care. |
| | | Any concern with medications. |
| Nutritional: | | Possible eating disorder? |
| | | Unregulated/unmedicated diabetic. |
| | | Any weight loss over 8 pounds or gain over 10 pounds in one month. |
| Dental: | | Any concern for oral hygiene or dental care? |
| Pain: | | Any “Yes” response. |

INDICATE DATE REFERRED TO A PROGRAM PHYSICIAN OR DOES NOT APPLY (DNA):

| | |
|---|---|
| SIGNATURE OF REVIEWING STAFF/CREDENTIALS: | DATE: |

PHYSICIAN RECOMMENDATIONS
(Indicate what recommendations or note “None”):

| | |
|---|---|
| PHYSICIAN SIGNATURE (When required) | DATE: |

CLIENT NAME: I.D.:

| YOU ARE NOT REQUIRED TO COMPLETE THE FOLLOWING QUESTIONS. THIS INFORMATION WILL BE KEPT IN A SECURE FILE AND NOT INCLUDED IN YOUR MEDICAL RECORDS. | | | | |
|---|---|---|---|---|
| Have you been diagnosed with HIV or AIDS? | | No | | Yes, when? |
| Are you currently receiving treatment for this condition? | | No | | Yes |
| If Yes, what medication do you take? | | | | ______ |
| If Yes, what doctor is treating you for this condition: | | | | |
| If Yes, what medical conditions do you have related to HIV/AIDS? | | | | ______ |

CLIENT NAME: I.D.: