BOARDER HEALTH HISTORY SCREENING

Name: ______________________________ DOC #: ______________________________

Birthdate: __________________ Gender: ☐ Male ☐ Female ☐ Other - ______________

Sending jurisdiction: ____________________ Receiving facility: ____________________

Reason for request: ☐ Behavior ☐ Security ☐ Safety ☐ Medical ☐ Mental Health ☐ Unknown

CURRENT MEDICATIONS (list below or ☐ Medication Administration Record (MAR) attached)		

ALLERGIES/SENSITIVITIES (list below or ☐ MAR attached)		

TEST RESULTS		
Test	**Results/treatment**	**Date**
Purified Protein Derivative (PPD)	__________ mm	
Chest x-ray, if PPD positive	WNL / ABN	
Hepatitis C status	NOT DET / DET	
Hepatitis C treatment completed?	Yes / No	
Hepatitis A	- / +	
Hepatitis B	- / +	
HIV/AIDS	- / +	

CONSIDERATIONS
Physical/functional limitations or durable medical equipment required? ☐ No ☐ Yes, specify:
Accidents/injuries? ☐ No ☐ Yes, specify:
Special housing? ☐ No ☐ Yes, specify:

MENTAL HEALTH HISTORY
History of self-harm (check all that apply)? ☐ No ☐ Yes, last known date: _____ Specify: ☐ Suicide attempts, how many? _____ ☐ Self-injurious behavior ☐ Unknown ☐ Other -
History of suicidal ideation? ☐ No ☐ Yes, last known date: _____
Mental health diagnosis:
Past mental health treatment (check all that apply): ☐ Psychiatric hospital ☐ Residential mental health in correctional setting ☐ Supported housing ☐ Outpatient treatment ☐ Involuntary treatment ☐ None ☐ Unknown

HISTORY OF OPERATIONS/ACCIDENTS											
Operation	**Yes**	**No**	**Date**	**Operation**	**Yes**	**No**	**Date**	**Operation**	**Yes**	**No**	**Date**
Hernia	☐	☐		Gall bladder	☐	☐		Splenectomy	☐	☐	
Back/neck	☐	☐		Hysterectomy	☐	☐		Abortion/D&C	☐	☐	
Appendix	☐	☐		Gunshot wound	☐	☐		Hemorrhoid	☐	☐	
Bone/joint fracture	☐	☐		Other -				Other -			

HISTORY OF DISEASES											
Disease	**Yes**	**No**	**When**	**Disease**	**Yes**	**No**	**When**	**Disease**	**Yes**	**No**	**When**
Tuberculosis	☐	☐		High blood pressure	☐	☐		Liver disease	☐	☐	
Asthma	☐	☐		Heart attack	☐	☐		Seizures	☐	☐	
Lung disease	☐	☐		Stroke	☐	☐		HIV/AIDS	☐	☐	
Diabetes	☐	☐		Hernia	☐	☐		Arthritis	☐	☐	
Multiple Sclerosis	☐	☐		Bleeding problems	☐	☐		Sickle cell disease	☐	☐	
Peptic ulcers	☐	☐		Urinary/kidney	☐	☐		Mental illness	☐	☐	
Cancer	☐	☐		Other -				Other -			
If yes, type/location -											

OBSTETRICS/GYNECOLOGY HISTORY (if applicable)			
☐ Pregnant	Number of pregnancies: _____	Number of live births: _____	Number of miscarriages: _____
Last breast exam: _____		Result: _____	
Last mammogram: _____		Result: _____	
Last pap smear: _____		Result: _____	
Flushing/menopause: _____		Other: _____	

HISTORY OF TOBACCO/ALCOHOL/DRUG USE AND TREATMENT

Previous substance use disorder treatment? ☐ No ☐ Yes, specify:
Dates of treatment: _____ Outcome:
Positive drug/alcohol tests during incarceration? ☐ No ☐ Yes

Substance	**Yes**	**No**	**Never**	**Date stopped**	**Amount per day**
Tobacco	☐	☐	☐		
Alcohol	☐	☐	☐		
Drug(s) of choice:	☐	☐	☐		

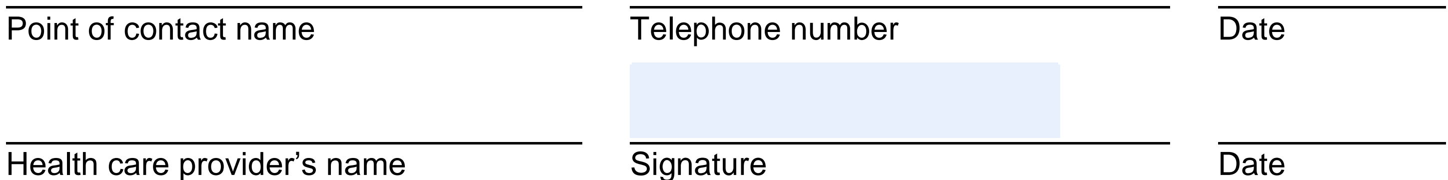
Comments: ____

____

____

Please attach the following documents, as applicable, and **fax** to the Nurse Desk at **(360) 586-9060**.
If you have any questions, call the Nurse Desk at **(360) 725-8733**.

☐ Chart notes ☐ MAR ☐ Intake summary ☐ Consult notes ☐ ER notes ☐ Hospital/clinical/medical notes



Point of contact name _______________ Telephone number _______________ Date _______________

Health care provider's name _______________ Signature _______________ Date _______________

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

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