## HEALTH HISTORY – PATIENT REPORT

### Recent General Symptoms (check all that apply)

- [ ] Anemia
- [ ] Abdominal pain
- [ ] Active dental abscess
- [ ] Bloody/tarry stools
- [ ] Breast lump or discharge
- [ ] Bruise easily
- [ ] Calf pain with walking
- [ ] Chest pain/tightness
- [ ] Chronic cough
- [ ] Coughing up blood
- [ ] Currently pregnant
- [ ] Decreased hearing
- [ ] Depression
- [ ] Difficulty swallowing
- [ ] Hallucinations
- [ ] Head injury
- [ ] Heartburn
- [ ] Heavy menses
- [ ] Irregular periods
- [ ] Joint pain/stiffness/swelling
- [ ] Kidney stones
- [ ] Loss of consciousness/dizziness
- [ ] Loss of vision
- [ ] Lumps on neck or under arms
- [ ] Neck stiffness
- [ ] Night sweat
- [ ] Pain/frequency with urination
- [ ] Palpitations/irregular heart beats
- [ ] Paralysis
- [ ] Past positive PPD
- [ ] Persistent nausea/vomiting
- [ ] Aversion to lights
- [ ] Prostate problems
- [ ] Rash or itching
- [ ] Shortness of breath
- [ ] Suicidal thoughts
- [ ] Swollen ankles
- [ ] Throat problems
- [ ] Unwanted weight changes
- [ ] Other:

### Health History (check all that apply)

- [ ] Anemia
- [ ] Angioedema
- [ ] Asthma
- [ ] Cancer
- [ ] Chickenpox
- [ ] Crohn’s Disease/ulcerative colitis
- [ ] Diabetes
- [ ] Eczema/dermatitis
- [ ] Emphysema or chronic bronchitis
- [ ] Gastrointestinal bleeding
- [ ] Gonorrhea or Chlamydia
- [ ] Heart disease
- [ ] Hemophilia
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] Date first diagnosed: __________
- [ ] Where diagnosed: __________
- [ ] Genotype: __________
- [ ] Latest HCV viral load: __________
- [ ] Past treatment: __________
- [ ] Hernia
- [ ] Herpes
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] HIV/AIDS
- [ ] Past and current treatments:
- [ ] Last viral load: __________
- [ ] Last CD4 count: __________
- [ ] Lowest CD4 count: __________
- [ ] Kidney disease
- [ ] Liver disease or cirrhosis
- [ ] Lump of any kind
- [ ] Mental health/emotional problem
- [ ] MRSA
- [ ] Ovarian cysts
- [ ] Rheumatic fever
- [ ] Rubella
- [ ] Seizure disorder
- [ ] Shingles
- [ ] Scabies
- [ ] Stomach ulcers
- [ ] Stroke
- [ ] Syphilis
- [ ] Thyroid disease
- [ ] Treatment for TB
- [ ] When: __________
- [ ] Where: __________
- [ ] Length of Treatment: __________
- [ ] Medications used: __________
- [ ] Other:

Details of Health History items checked above

- [ ] No serious health problems

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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.

HISTORY AND PHYSICAL

Facility:          Date:

**Surgical and Trauma History** (check all that apply)

- [ ] Abortion or D&C
- [ ] Amputation
- [ ] Appendix removal
- [ ] Back surgery
- [ ] Breast implants
- [ ] Fracture repair
- [ ] Gall bladder removal
- [ ] Gunshot or stab wound
- [ ] Hernia repair
- [ ] Hysterectomy
- [ ] Liver biopsy
- [ ] Plates/Pins/Screws
- [ ] Serious injuries
- [ ] Skin biopsy
- [ ] Spleen removal
- [ ] Transgender modification
- [ ] Other abdominal surgery
- [ ] Other surgical hospitalization

Details of Surgical and Trauma History (include date, hospital, and details)

- [ ] No major surgery
- [ ] No major trauma

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**Social History**

<table>
<thead>
<tr>
<th>SUBSTANCE</th>
<th>NO/ NONE</th>
<th>AMOUNT PER WEEK</th>
<th>NUMBER YEARS USED</th>
<th>DATE OF LAST USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco/smoking</td>
<td></td>
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<tr>
<td>Alcohol</td>
<td></td>
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<tr>
<td>Intravenous/injected drugs:</td>
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<tr>
<td>Other street drugs:</td>
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<tr>
<td>Other drugs of choice:</td>
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</tr>
</tbody>
</table>

Sexual partners:  [ ] Men  [ ] Women  [ ] Both
Number of sexual partners in past 6 months:  Number of sexual partners during lifetime:

- [ ] Yes
- [ ] No
  (If yes, ask patient to provide a copy)

Who is your healthcare proxy? Name:  Telephone:  [ ] None

Usual occupation:

Describe any claim with Labor and Industries:  [ ] None
If yes, claim is:  [ ] Open  [ ] Closed
Claim number, if known:

Describe any physical limitations:  [ ] None

**Immunizations and Preventive Health History** (provide dates for all received)

- Hepatitis A:  [ ] Hepatitis B:  [ ] Tetanus:
- Flu shot:  [ ] Pneumovax:  [ ] Chicken pox:
- Measles, mumps, rubella:  [ ] Other vaccination:
- Last physical exam:  [ ] Last eye exam:  [ ] Rectal exam:
- Colonoscopy:  [ ] Fecal occult blood test:
- Last PSA:  [ ] PSA Value:
### FAMILY HISTORY

<table>
<thead>
<tr>
<th>Adopted</th>
<th>FATHER</th>
<th>MOTHER</th>
<th>SIBLINGS</th>
<th>CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Age if alive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age of death</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>High blood pressure</td>
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</tr>
<tr>
<td>Heart disease</td>
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</tr>
<tr>
<td>Diabetes</td>
<td></td>
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<tr>
<td>Strokes</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Mental health disease</td>
<td></td>
<td></td>
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<tr>
<td>Other:</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### OB/GYNECOLOGIC HISTORY (female patients only)

<table>
<thead>
<tr>
<th>Menarche (age of onset of periods):</th>
<th>Frequency (length of cycle):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of period:</td>
<td>Flow: [ ] Regular [ ] Irregular</td>
</tr>
<tr>
<td>Pain/cramps with flow:</td>
<td>Last menstrual period:</td>
</tr>
<tr>
<td>Number of pregnancies:</td>
<td>Number of live births:</td>
</tr>
<tr>
<td>Number of miscarriages:</td>
<td></td>
</tr>
<tr>
<td>Birth control method:</td>
<td>Date of last sexual encounter:</td>
</tr>
<tr>
<td>Last breast exam:</td>
<td>Result:</td>
</tr>
<tr>
<td>Last mammogram:</td>
<td>Result:</td>
</tr>
<tr>
<td>Last Pap smear:</td>
<td>Result:</td>
</tr>
<tr>
<td>[ ] History of abnormal Pap</td>
<td>Date(s):</td>
</tr>
<tr>
<td>Vaginal discharge:</td>
<td>Flushing/menopause:</td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
</tr>
<tr>
<td>PATIENT SIGNATURE</td>
<td>DATE</td>
</tr>
</tbody>
</table>

STOP! END OF PATIENT REPORT

### CURRENT MEDICATIONS

(list drug name, dosage, and reason for taking)  [ ] None

### ALLERGIES/SENSITIVITIES

(medications, foods, dyes, latex, hay fever)  [ ] None  ➤ Update Problem List ➤
### History and Physical

**Physical Examination**

<table>
<thead>
<tr>
<th>Facility:</th>
<th>Date of entry to DOC:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam type:</td>
<td>Date of exam:</td>
</tr>
<tr>
<td>☐ Entry</td>
<td>☐ Periodic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
<th>SaO₂:</th>
<th>Temperature:</th>
<th>Respiration:</th>
<th>Pulse:</th>
<th>Blood pressure:</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Visual acuity – Uncorrected</th>
<th>Right:</th>
<th>Left:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Visual acuity – Corrected</th>
<th>Right:</th>
<th>Left:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing – Specify method (e.g., spoken voice, audiometer)</th>
<th>Normal</th>
<th>Diminished</th>
<th>Normal</th>
<th>Diminished</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Chief Complaint** (if applicable)

☐ None

**History of Present Illness** (if applicable)

☐ Not applicable

**General Appearance**

<table>
<thead>
<tr>
<th>☐ Well developed, well nourished</th>
<th>☐ In no apparent distress</th>
</tr>
</thead>
</table>

**HEENT**

<table>
<thead>
<tr>
<th>☐ Within normal limits</th>
</tr>
</thead>
</table>

Significant findings:

**Neck**

<table>
<thead>
<tr>
<th>☐ Supple, no palpable mass, no bruit</th>
</tr>
</thead>
</table>

Significant findings:

**Chest**

<table>
<thead>
<tr>
<th>☐ Clear to auscultation</th>
</tr>
</thead>
</table>

Significant findings:

**Heart**

<table>
<thead>
<tr>
<th>☐ Normal rhythm and rate, no murmurs heard</th>
<th>☐ Heart sounds normal</th>
</tr>
</thead>
</table>

Significant findings:
### General Appearance – Continued

<table>
<thead>
<tr>
<th>Facility:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdomen</td>
<td>□ Soft, non-tender, non-distended, no palpable mass, bowel sounds present</td>
</tr>
<tr>
<td>Significant findings:</td>
<td></td>
</tr>
</tbody>
</table>

| Extremities/Joints | □ No edema, no limitation of range of motion |
| Significant findings: | |

| Genitourinary | □ Deferred □ Normal external genitalia □ No testicular mass, no hernia |
| Significant findings: | |

| Neurologic | □ Motor/sensory screen normal, alert and oriented x 3, no deficits |
| Significant findings: | |

| Skin | □ Normal turgor, no apparent lesion seen |
| Significant findings: | |

| Breast/Axilla | □ Deferred □ No breast mass, no palpable axillary mass □ No exudate |
| Significant findings: | |

| Pelvic | □ Deferred □ Not indicated |
| Findings: | |

| Prostate | □ Deferred □ Not enlarged, no nodules felt □ Not indicated |
| Significant findings: | |
### HISTORY AND PHYSICAL

**Facility:**

**Date:**

<table>
<thead>
<tr>
<th>General Appearance – Continued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rectal</td>
</tr>
<tr>
<td>Significant findings:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

- [ ] Patient refused physical examination. Refusal of treatment form (13-048) completed.

### ASSESSMENT

<table>
<thead>
<tr>
<th>Problem List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter on DOC 13-378 Problem List/Surveillance</td>
</tr>
</tbody>
</table>

### Impression

### Diagnostic Plan

- [ ] Hepatitis panel (test code 6519)
- [ ] Fecal occult blood test
- [ ] HIV test (test code 6449)
- [ ] Patient declines HIV test

### Records to be Requested

- [ ] None
### Treatment Plan

- **None**

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**Treatment Plan – Continued**

- Patient declined hepatitis testing. Begin Twinrix (Hepatitis A/B) vaccination series. Give first vaccine now then #2 and #3 at 1 and 6 months respectively.
- Patient accepted hepatitis testing. Will evaluate the need for vaccination after laboratory results are reviewed.
- **Sick Call/Periodic Physical PRN**
- **Follow-up:**

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**Housing:**

- General Population
- Infirmary
- **Other:**

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**Restrictions:**

- None
- No DNR/Firefighting

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**Healthcare Practitioner (stamp/print)**  
**Healthcare Practitioner signature**  
**Date**

---

**Reviewing Physician (if required) (stamp/print)**  
**Reviewing Physician signature**  
**Date**