Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA:
(name, DOC #, birthdate)

HISTORY AND PHYSICAL

Facility: Date:

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 sweats	☐ 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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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

Social History

SUBSTANCE	NO/ NONE	AMOUNT PER WEEK	NUMBER YEARS USED	DATE OF LAST USE
Tobacco/smoking				
Alcohol				
Intravenous/injected drugs:				
Other street drugs:				
Other drugs of choice:				

Sexual partners: ☐ Men ☐ Women ☐ Both

Sex for money and/or drugs: ☐ Yes ☐ No

Number of sexual partners in past 6 months:

Number of sexual partners during lifetime:

Do you have a living will or advance directive? ☐ 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:	

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Family History				
☐ Adopted	FATHER	MOTHER	SIBLINGS	CHILDREN
Age if alive				
Age of death				
Cancer				
High blood pressure				
Heart disease				
Diabetes				
Strokes				
Mental health disease				
Other:				

OB/Gynecologic History (female patients only)

Menarche (age of onset of periods):	Frequency (length of cycle):	
Length of period:	Flow: ☐ Regular ☐ Irregular	
Pain/cramps with flow:	Last menstrual period:	
Number of pregnancies:	Number of live births:	Number of miscarriages:
Birth control method:	Date of last sexual encounter:	
Last breast exam:	Result:	
Last mammogram:	Result:	
Last Pap smear:	Result:	
☐ History of abnormal Pap	Date(s):	
Vaginal discharge:	Flushing/menopause:	Other:

PATIENT SIGNATURE	DATE

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** ⋚

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PHYSICAL EXAMINATION	
Facility:	Date of entry to DOC:
Exam type: ☐ Entry ☐ Periodic ☐ Inpatient	Date of exam:

Height:	Weight:	$Sa0_2$:	Temperature:
Respirations:	Pulse:	Blood pressure:	
Visual acuity – Uncorrected	Right:	Left:	
Visual acuity – Corrected	Right:	Left:	
Hearing – Specify method (e.g., spoken voice, audiometer)	Right: ☐ Normal ☐ Diminished	Left: ☐ Normal ☐ Diminished	

Chief Complaint (if applicable)
☐ None

History of Present Illness (if applicable)
☐ Not applicable

General Appearance	☐ Well developed, well nourished	☐ In no apparent distress
HEENT Significant findings:	☐ Within normal limits	
Neck Significant findings:	☐ Supple, no palpable mass, no bruit	
Chest Significant findings:	☐ Clear to auscultation	
Heart Significant findings:	☐ Normal rhythm and rate, no murmurs heard	☐ Heart sounds normal

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Facility: Date:

General Appearance – Continued

Abdomen Significant findings:	☐ Soft, non-tender, non-distended, no palpable mass, bowel sounds present		
Extremities/Joints Significant findings:	☐ No edema, no limitation of range of motion		
Genitourinary Significant findings:	☐ Deferred	☐ Normal external genitalia	☐ No testicular mass, no hernia
Neurologic Significant findings:	☐ Motor/sensory screen normal, alert and oriented x 3, no deficits		
Skin Significant findings:	☐ Normal turgor, no apparent lesion seen		
Breast/Axilla Significant findings:	☐ Deferred	☐ No breast mass, no palpable axillary mass	☐ No exudate
Pelvic Findings:	☐ Deferred	☐ Not indicated	
Prostate Significant findings:	☐ Deferred	☐ Not enlarged, no nodules felt	☐ Not indicated

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General Appearance – Continued

Rectal ☐ Deferred ☐ No palpable mass/hemorrhoids ☐ Not indicated

Significant findings:

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

ASSESSMENT

Problem List
Enter on DOC 13-378 Problem List/Surveillance

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

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Treatment Plan ☐ None

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: _____

P	U	L	H	E	S	D	X	T

Restrictions: ☐ None ☐ No DNR/Firefighting

Housing: ☐ General Population ☐ Infirmary ☐ Other:

Healthcare Practitioner (stamp/print)	Healthcare Practitioner signature	Date
Reviewing Physician (if required) (stamp/print)	Reviewing Physician signature	Date