Health Screening

Patient Name: _____ Today's Date: _____

DOB: _____ Age: _____ Sex: _____

Date of Last Physical Exam: _____

Medication Allergies: _____

_____

Are you currently in pain? Yes or No

If yes, are you being seen by a doctor for it? Yes or No

Are you having any thoughts to hurt yourself? Yes or No

Are you currently pregnant? Yes or No

Do you have diabetes? Yes or No

History of Seizure/Last Seizure: _____

Any Physical Limitations/Disabilities: _____

Prescription Medications & Over-the-counter Medications Taken Frequently

Medication Name	Dose	How often are you supposed to take this medication?	How often are you taking this medication?	Last Used

Pharmacy Name and Phone Number: _____

_____

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Health Screening

Have you recently experienced any of the following:

General
Weight Loss
Weight Gain
Fatigue
Fever/Chills
Other

Eyes
Vision Changes
Other

Ear/Nose/Throat
Ringing in the Ears
Frequent Sore Throat
Snoring
Other

Cardiovascular
Heart Murmur
Chest Pain
Heart Racing
Dizziness
Fainting Spells
Other

Skin
Rash
Itching
Other

Endocrine
Heat/Cold Intolerance
Excessive Thirst & Urination
Change in Menstrual Cycle
Other

Respiratory
Cough
Shortness of Breath
Other

Gastrointestinal
Heartburn/Reflux
Nausea/Vomiting
Constipation
Diarrhea
Abdominal Pain
Black or Bloody Stools
Other

Hematology
Easy Bruising
Gums Bleed Easily
Other

Musculoskeletal
Muscle Pain
Loss of Strength
Other

Neurological
Headaches
Tremors/Shaking
Stiffness
Trouble Walking
New Onset Weakness
Other

Medical Diagnosis/Health Problems Currently Being Treated: _____

_____

By Whom: _____

Patient Signature: _____ Date/Time: _____

Health Screening

After reviewing patient's health screening:

☐ No Recommendations/Referrals needed at this time.

☐ Recommendations Given: _____

_____

_____

☐ Medical Referrals Provided: _____

_____

_____

Nurse Signature: _____ Date/Time: _____

Doctor Signature: _____ Date/Time: _____