PATIENT SELF-ASSESSMENT FORM FOR INITIAL PRIMARY CARE OUT-PATIENT VISIT

*We ask that all of our patients fill out this form at the time of their first visit. Please do your best to answer all the questions. If you do not understand a question, our staff can explain it. Everything is **CONFIDENTIAL** and part of your medical record.*

Name:	**Date of Birth:**	**Visit Date:**
Reason for Visit/ CC:		
History of Present Illness:		
• *Any pain?* ☐ no ☐ yes *If yes,* how severe? ☐ mild (1 – 3) ☐ moderate (4 – 6) ☐ severe (7 – 10)		
• *Where is the pain?*		

Review of Systems: *Have you had …*			**Review of Systems: *Have you had …***		
• CONSTITUTIONAL	**YES**	**NO**	**• EYES**	**YES**	**NO**
Any recent weight change	☐	☐	Vision change in past 6 months	☐	☐
Fatigue > 6 months	☐	☐	Wear glasses/ contact lenses	☐	☐
• RESPIRATORY			**• EARS/ NOSE/ THROAT**		
Chronic/ frequent cough	☐	☐	Change in hearing in past 6 months	☐	☐
Shortness of breath	☐	☐	Voice change	☐	☐
• CARDIOVASCULAR			Frequent nose bleeds	☐	☐
Chest pain	☐	☐	**• GASTROINTESTINAL**		
Palpitation/ irregular heart beat	☐	☐	Nausea/; vomiting	☐	☐
Cannot climb 2 flights of stairs	☐	☐	Change in bowel habits	☐	☐
• MUSCULOSKELETAL			**• GENITOURINARY**		
Painful/ swollen joints	☐	☐	Blood in urine	☐	☐
Difficulty in walking	☐	☐	Difficulty holding urine	☐	☐
• NEUROLOGICAL			**• PSYCHIATRIC**		
Chronic/ frequent headaches	☐	☐	Feeling depressed/ sad lately	☐	☐
Convulsions/ seizures	☐	☐	Nervous/ anxious	☐	☐
Memory problems	☐	☐	Suicide attempt	☐	☐
• ENDOCRINE			**• SKIN**		
Any loss in height	☐	☐	Hair loss/ excess hair growth	☐	☐
Excessive thirst/ urination	☐	☐	Rashes/ itching	☐	☐
• FOR WOMEN ONLY			***• FOR MEN ONLY***		
Abnormal vaginal discharge/ bleeding	☐	☐	Discharge from penis	☐	☐
Discharge/ lump in breast	☐	☐	Lump on testicles	☐	☐

Name:				Date of Birth:		Visit Date:	
PREVENTIVE HEALTH	**NO**	**YES**	**Date Done**	**SOCIAL HISTORY**	**NO**	**YES**	**Comments**
Tetanus – diphtheria vaccine				Present alcohol use			
Pneumococcal vaccine				Past/ present smoking			
Influenza vaccine				Wears seat belt in car			
MMR vaccine				Regular exercise			
Hepatitis B vaccine				Any religious concerns			
Pap smear				Any cultural concerns			
Breast exam/ mammogram				Healthcare proxy			
Colonoscopy/ sigmoidoscopy				Level of education: ☐ grade school ☐ H.S. ☐ college			
Bone density study				Kind of work you do:			
				Others:			
ALLERGIES TO FOOD/ MEDICINE: ☐ NO ☐ YES							
Specify allergy:							
FOR WOMEN ONLY:				***FOR WOMEN ONLY:***			
Date of Last Menstrual Period:				# Pregnancies:			
Age of 1st menstruation:				# Miscarriages/ Abortions:			
Age of Menopause:				# Live Births:			
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect							
information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.							
I also authorize the healthcare staff to perform the necessary services I may need. Date:							
				Above information reviewed and confirmed with the patient.			
Signature of Patient/ Guardian:				Signature of Medical Staff:			