North Shore LIJ North Shore-Long Island Jewish Health System

# HEALTH ASSESSMENT
(Confidential)

NAME_____ D.O.B._____ DATE_____

DATE OF LAST PHYSICAL EXAMINATION_____ WHAT IS YOUR REASON FOR VISIT? _____

SYMPTOMS: CHECK SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

**GENERAL**
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

**MUSCLE/JOINT/BONE**
- ☐ Arms
- ☐ Hands
- ☐ Shoulders
- ☐ Neck
- ☐ Back
- ☐ Hips
- ☐ Legs
- ☐ Feet

**GENITO-URINARY**
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

**GASTROINTESTINAL**
- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Ingestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

**CARDIOVASCULAR**
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

**EYE, EAR, NOSE, THROAT**
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing

**EYE, EAR, NOSE, THROAT**
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

**SKIN**
- ☐ Bruise easily
- ☐ Hives Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

***WOMAN ONLY***

Date of Last Pap Smear _____

Have you had a Mammogram?
☐ Yes ☐ No

Number of children?_____

CONDITIONS: CHECK CONDITION YOU HAVE OR HAVE HAD IN THE PAST

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

LIST ALLERGIES TO MEDICATION S OR SUBSTANCES AND REACTION:

MEDICATIONS: LIST MEDICATION S YOU ARE CURRENTLY TAKING VITAMINS AND HERBEL SUPLEMENTS AND DOSAGE:

Have you ever been on or are you currently on Plavix **YES / NO**__

PLEASE COMPLETE THE FRONT AND BACK OF THIS FORM