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

North Shore LIJ North Shore-Long Island Jewish Health System

NAME_____ D.O.B._____

(ALL INFORMATION IS STRICTLY CONFIDENTIAL)

HOSPITALIZATIONS					
YEAR	HOSPITAL	REASON FOR HOSPITALIZATION & OUTCOME	SERIOUS ILLESS/INJURIES	DATE	OUTCOME

Is the referring physician your Primary Care Physician? □ YES □ NO

Please indicate the name, address and phone number of you Primary Care Physician:

_____

Name of Primary Care Physician Address Telephone Number

Did you ever have a blood transfusion? □ YES □ NO If yes, please give approximate Date(s):_____

HEALTH HABITS: CHECK WHICH SUBSTANCES YOU USE AND DESCRIBE HOW MUCH YOU USE			OCCUPATIONAL CONCERNS: CHECK IF YOUR OCCUPATION EXPOSES YOU TO THE FOLLOWING:	
√	SUBSTANCE	DESCRIPTION OF USE		EXPOSURES
	Caffeine			Stress
	Tobacco (Did you smoke within the last 12 months?)			Hazardous Substances
				Heavy Lifting
	Illicit Drugs			Other
	Alcohol			
			YOUR OCCUPATION:	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature Date

□ *ROS and PMFSH on Patient History Form Reviewed and Discussed with Patient*

□ *Patient states all other ROS is negative*

_____ _____

MD SIGNATURE Date