Dignity Health

PATIENT NAME: ______________________

MRN: ______________________

DOB: ______________________

Health Assessment

ALLERGIES/REACTIONS:

MEDICATIONS: INCLUDING SUPPLEMENTS, LIST NAME OF MEDICATION, DOSE AND FREQUENCY.

Name	Dose	Frequency

Medical Illness:

- ☐ Adrenal tumor/mass
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Blood Clots
- ☐ Blood Pressure High/Low
- ☐ Bone Infections
- ☐ Bowel Problems
- ☐ Cancer*
- ☐ Chicken Pox
- ☐ Colon Polyps
- ☐ Concussion
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Gallstones
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hemophilia/Abnormal Bleeding
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Lung Disease
- ☐ Lymphatic disease
- ☐ Mononucleosis
- ☐ Neurological Disorder
- ☐ Pancreatic tumor/mass
- ☐ Parkinsons
- ☐ Pituitary tumor/mass
- ☐ Pneumonia
- ☐ Prostate Enlargement
- ☐ Psychiatric Problems
- ☐ Seasonal Allergies/ Hay Fever
- ☐ STD______________
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tumor/Mass
- ☐ Tuberculosis/Exposure
- ☐ Ulcers
- ☐ Valley Fever
- ☐ Other: ______________________

Surgeries:

- ☐ Appendix
- ☐ Back Surgery
- ☐ Breast Biopsy
- ☐ Cardiac
- ☐ Colon Polyps
- ☐ Gall Bladder
- ☐ Hemorrhoid
- ☐ Hernia (Umbilical or Inguinal)
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Knee Surgery
- ☐ Ovarian
- ☐ Prostate
- ☐ Shoulder Surgery
- ☐ Skin Biopsy
- ☐ Splenectomy
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Vasectomy
- ☐ Other: ______________________

Cancer History*:

- ☐ Breast
- ☐ Colon
- ☐ Lung
- ☐ Prostate
- ☐ Ovarian
- ☐ Skin
- ☐ Stomach
- ☐ Other: ______________________

Dignity Health

PATIENT NAME: ____________________
MRN: ____________________
DOB: ____________________

Health Assessment

Please complete the following information regarding the patient's biological family.
If the biological family history is unknown please check here: ☐

FAMILY HISTORY

Problem	Biological Mother/Type	Biological Father/Type	Biological Siblings/Type
Developmental Delays			
Diabetes			
Cardiac Problems			
Kidney Disease			
Thyroid Problems			
Stroke			
Liver Disease			
High Cholesterol			
Seizures/Epilepsy			
Heart Murmur			
Psychiatric Illness			
Cancer/Type			
Gastric Reflux			
Arthritis			
Other			

Obstetrical History:
Pregnancies___________ # Deliveries____________
Miscarriages ___________ # Abortions____________
Contraception/Type:___________________________
Menarche (Age Menstruation Began)______________
Date of Last Menstrual Period __________________

Vaccination(s) & Date:
- ☐ Tetanus ____________________
- ☐ TDAP (Tetanus/Diphtheria/Pertussis) ____________________
- ☐ Hepatitis A ____________________
- ☐ Hepatitis B ____________________
- ☐ MMR ____________________
- ☐ Varicella ____________________
- ☐ Shingles ____________________
- ☐ Other: ____________________

Clinicians you see: Please include name, specialty and phone number.
____
____
____

Pharmacy Information*:
Name:__________________ Phone: ___________ Location:___________________ Mail Order Pharmacy:____________________________
If multiple, please use space to list any/all preferred pharmacies

Preferred Lab:
Name:____

Do you have an Advanced Directive in Place (Living Will and/or Medical Durable Power of Attorney)? ☐ Yes ☐ No

FOR OFFICE USE ONLY

Date:	Medical Record #

Advanced Directives: ☐ Patient refused
☐ Scanned in Chart ☐ Pt Completed AD at Home ☐ Provided AD Informational Brochure ☐ Pt Requested More Information