## **Health Assessment Form**

Patient information					
Name:	Date of birth:				
Gender:	Contact information:				
Address:					
Emergency contact person:					
Emergency contact person's contact number:					
Date of assessment:					
Vitals					
Temperature:	Heart rate:				
Blood pressure:	SPO2:				
Respiratory rate:					
Medical history					
1. Primary care provider:					
2. Phone number:					
3. Date of last medical consultation:					
4. Current medications:					
Please list all medications, including prescription and over-the-counter.					
5. Allergies:					
Please list any known allergies to medications, food, or environmental factors.					

6. Past medical history:						
Check all that apply.						
Diabetes	Asthma					
Hypertension	Heart disease					
Other (please specify):						
Lifestyle habits						
1. Smoking status:						
Never smoked	Former smoker					
Current smoker (packs/day):						
2. Alcohol consumption:						
None	Occasional					
Regular (units/week):						
3. Exercise frequency:						
Sedentary	3-4 times/week					
1-2 times/week	5 or more times/week					
3. Dietary habits:						
Describe your typical daily diet.						
Psychological information						
1. Current stressors:						
Please describe any current life stressors or challenges.						
2. Mental health history:						
Check all that apply.						
Depression	PTSD					
Anxiety	Other (please specify):					

3. Current mental health support:								
None	None			Counseling/therapy				
Support groups			Other (please specify):					
Medication (please specify):								
4. Emotional well-being scale (1-10):								
Rate your current emotio	onal well-being	<i>J.</i>						
1 2	3 4	5	6 7	7 8	9	10		
5. Suicidal thoughts or	self-harm:							
Yes			No					
If yes, please elaborate:								
Physical assessment								
Category	Not examined	Normal	Abnormal		Remarks			
General appearance								
Head/ear/nose/throat								
Mouth (an a a h								
Mouth/speech								
Cardiovascular								
Cardiovasculai								
Vascular								
Vasculai								
Lungs and chest								
Lungs and chest								
Abdomen and viscera								
Lymphatic								

Category	Not examined	Normal	Abnormal	Remarks		
Back/spine						
Extremities/joints						
Endocrine						
Genito-urinary						
Skin						
Locomotor						
Neurological system						
Gait						
Psychiatric						
Notes/recommendations:						
Healthcare practitioner's name:						
Designation:						
Signature:						
Date of examination:						

Agency for Healthcare Research and Quality. (2012). *Appendix 10: Health assessment information for patients*. <u>https://www.ahrq.gov/ncepcr/tools/assessments/health-ap10.html</u>