

Patient Assessment

Patient Information			
Name:			
Date of birth:		Gender:	
Occupation:		Mobile number:	
Height:	Weight:	Race/Ethnicity:	
Reason for visit:			
Social Habits			
Alcohol: ☐ No ☐ Yes (frequency):			
Cocaine: ☐ No ☐ Yes		Narcotics/Drug use: ☐ No ☐ Yes	
Smokes Tobacco: ☐ No ☐ Yes If yes, # of years: # of packs a day: When stopped:			
Cultural/religious beliefs that may affect care ☐ No ☐ Yes (please specify)			
Do you prefer to learn by:			
☐ Seeing (TV, Video, Written) ☐ Hearing (Audio) ☐ Doing (Hands On)			
Do you have any barriers to learning (please check):			
☐ Physical ☐ Emotional ☐ Vision ☐ Financial ☐ Hearing ☐ Cognitive			
Hospitalization/Surgery/Major Illness			
Problem	Year	Where treated	Days in hospital
Gynecologic/Obstetric History			
Any Pregnancies? ☐ No ☐ Yes (how many)			
How many children have you given birth to?			
How many abortions/miscarriages?			
Going through menopause? ☐ No ☐ Yes			
Date of last period:			
Monthly breast exams? ☐ No ☐ Yes			
Lumps on breasts? ☐ No ☐ Yes			
Date of last mammogram:			

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Medications (Please list all medications you are currently taking, including vitamins and supplements)		
1.		
2.		
3.		
4.		
5.		
Any previous bleeding problems? ☐ No ☐ Yes		
Have you used herbal medications? ☐ No ☐ Yes		
Any allergy to medication? ☐ No ☐ Yes (type of reaction)		
Any food allergies? ☐ No ☐ Yes (please specify)		
Nutritional Data		
Are you following a special diet? ☐ No ☐ Yes (please specify)		
Unintentional Weight ☐ Over/Under 5 lbs in 1 month ☐ Over/Under 10 lbs in 3-6 months		
Appetite ☐ Good (eat 3+ meals/day) ☐ Fair (1-2 meals/day) ☐ Poor (less than 1 meal/day)		
Personal/Family History		
IF YES	Patient/How often	Family/How often
Allergies		
Amputation		
Anesthesia Problems		
Angina		
Anxiety or Depression		
Asthma		
Bleeding/Bruising Problems		
Bowel Problems		
Cancer		
Chest Pain/Heart Disease		
Diabetes Mellitis		
Dizziness		
Ear Problems		
Eye Problems		
Headaches		
Heartburn		
Hepatitis		

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