NEW INSIGHTS II MEDICAL HISTORY

1/1/2016

Name_____ Date of Birth: _____

Do you consider yourself to be in good health? _____ If not, why? _____

Have you had any serious illnesses or injuries? _____ If yes, please explain.

Have you had any hospitalization or operations? _____ If yes, please explain.

Do you have any allergies?_____ If yes, please explain.

Are you taking any over the counter or prescribed medication? _____ If yes, please complete below.

Name of Medication	Dosage	How many times a day

Are you at risk for TB? (PLEASE ANSWER THE TB QUESTIONS ON SECOND PAGE)

When was your last:

Pap Smear _____ Physical Examination _____ Visit to the doctor for any reason _____

Are you using birth control?_____ If yes, what type? _____

Substance Use:	Daily amount	How long used	How used	List any withdrawal symptoms
Tobacco				
Caffeine				
Alcohol				

Have you ever had any treatment for drug or alcohol problems? _____ **If yes, please list:**

Family Medical History: Please indicate a (+) or (-) for each item below. A (+) indicates that it applies to your family.

_____ Diabetes_____
_____ Heart Disease_____
_____ Hepatitis_____
_____ High Blood Pressure_____
_____ Jaundice _____
_____ Kidney Disease_____
_____ Cancer_____
_____ Stroke _____
_____ Arthritis_____
_____ Anemia_____
_____ Headaches_____
_____ Mental Health Problems/ Nerve Problems_____
_____ Problem Drinkers_____

Who is your family doctor?_____ Phone #_____

Address: _____

If you are interested in how to obtain information regarding the risk factors of HIV, arrangements can be made through this agency.

FOR OFFICE USE ONLY:

Disposition based on Medical History:

_____ Medical History does not warrant any additional medical attention at this time
_____ Client encouraged to follow up with family physician
_____ Other: Specify: _____

_____ _____

Reviewed by: Date

TB AT RISK QUESTIONS

Screen the client to determine whether or not the client would be considered high risk for TB as follows:

PLEASE CIRCLE YES OR NO

YES NO 1. Have you traveled extensively (more than 4 weeks) outside the U.S. in the last five years to high tuberculosis incidence areas (Asia, Africa, South America, and Central America)?

YES NO 2. Are you a recent immigrant (within the past 5 years) from a high tuberculosis risk foreign country (includes counties in Asia, Africa, South America, and Central America)?

YES NO 3. Have you resided in any of these facilities in the past year? (Jails, prisons, shelters, nursing homes and other long-term care facilities such as rehabilitation centers) *If residents of any of these facilities were tested within the past 3 months they don't need to be tested.

YES NO 4. Have you had any close contact with someone diagnosed with tuberculosis?

YES NO 5. Have you been homeless within the past year?

YES NO 6. Have you ever been an injection drug user?

YES NO 7. Do you or anyone in your household currently have the following symptoms such as a sustained cough for two or more weeks, coughing up blood, fever/chills, loss of appetite, unexplained weight loss, fatigue, night sweats?

If the client answered yes to any of the questions, please refer them to:

Capitol Region Health System
Hamilton Health Center Inc.
1821 Fulton Street
Harrisburg, PA 17102-1522
Main Phone (717) 232-9971

FOR OFFICE USE ONLY:

If client responded with a "yes" to any of the above questions:

Was client referred to a Public Health Clinic?
If yes, where? _____ If not, why? _____

Was the client referred to SCA ICM/RC staff for case management services?

Name of Case Manager _____

If not, why? _____