Medical History and Assessment Questionnaire

- ✓ Assess current and past medical issues of the Individual served that may impact current functioning.
- ✓ To be completed by Individual, family, and/or guardian, or by medical staff during assessment period (Dependent upon the needs and regulations of a program).
- ✓ To be reviewed by qualified Medical Professional (Nurse, PA, NP, MD, DO)

Data Field	Identifying Information Instruction
Organization and Program Name	Record the names of the Organization and the Program if applicable
Individual's Name	Record the first name, last name, and middle initial of the Individual being served. Order of name is at agency discretion.
Record #	Record your agency's established Record number for the Individual.
Date of Birth	Record the date of birth of the Individual. **(e.g. MM/DD/YYYY)**
Data Field	**Have you/individual had any of the following health problems?**
Have you/individual had any of the following health problems?	For each of the indicated health care problems, check the appropriate box to indicate if this condition is applicable to the Individual currently, in the past, never applicable, and/or part of family medical history. Complete requested details about the type of treatment and date(s) received for all conditions applicable to the Individual.
Please note the family history details of any of the above conditions and Individual's relationship to that family member	For any conditions noted above that are applicable to family history, provide details about the Individual's relationship to the family member and their health condition.
Data Field	**Have you/individual had any of the following symptoms?**
Have you/individual had any of the following symptoms in the last 12 months?	Check all boxes for any of the symptoms which the Individual has experienced in the past. If "Other" is selected, indicate the other symptoms experienced.
Data Field	**Immunizations**
Immunizations	This section is required for all children /adolescents and individuals with developmental disabilities. If known, the information can be provided for adults, otherwise, for adults check *Not Applicable* and skip to the next section. Check the boxes for all immunizations that the Individual has had or of the diseases that the Individual has had.
Immunizations within the past year	Indicate all immunizations that the Individual has had in the past year and whether they are up to date.
Family's perception of the Individual's health problems	If applicable, record the family's perception of the Individual's health.
Data Field	**Medical Hospitalizations**
Have you/individual had any medical hospitalizations/ surgical procedures in the past?	If the Individual was not hospitalized or had no surgical procedures in the past, check No. If the Individual was hospitalized or underwent surgical procedures in the past, check Yes and complete the requested information for each hospitalization/surgical procedure.

Hospital	If the Individual was hospitalized/underwent a surgical procedure in the past, indicate the hospital name.
City	Record the location for each hospital stay
Date	Record the date of each hospitalization/surgical procedure.
Reason	Record the reason for each hospitalization/surgical procedure.
Data Field	**Allergies/Drug Sensitivities**
Allergies/Drug Sensitivities	List all known food, medication, and other allergies for the Individual. Check *None* if no allergies/drug sensitivities are known and skip to next section.
Food	Check if the Individual has food allergies and specify their food allergies
Medicine	Check if the Individual has allergies to medication(s). Specify the medications to which the Individual is allergic. Indicate any drug sensitivities.
Other	If an Individual has an allergy or drug sensitivity that is not captured in one of the above categories, check this box and specify.
Data Field	**For Women Only**
Currently Pregnant	Check the applicable box. If currently pregnant, indicate the expected due date.
Receiving pre-natal healthcare	If currently pregnant, indicate if the Individual is currently receiving prenatal care and provide the full name of the provider and/or group
Are you currently breastfeeding?	Check the applicable box.
Any significant pregnancy history	Check the applicable box and provide details for any "Yes" response (i.e. miscarriages, termination of pregnancies).
Last menstrual period	Record the date of the Individual's last period.
Data Field	**Last Examination**
Doctor's/Dentist's/Specialist Names	Record the names of the primary care provider/dentist and the area of specialty of other doctors listed who conducted the last examination of the Individual.
Date	Record the date of the last examination.
Phone Number	If known, record the phone number for the doctor/dentist.
Data Field	**Height/Weight**
Height	Enter the Individual's current height.
If reporting for a child, has height changed in the past year?	Check the appropriate box. If Yes, indicate the total change in height for the past year.
Weight	Enter the Individual's current weight.
Has there been a significant weight change in the past year	Check the appropriate box. If Yes, indicate the total change in weight for the past year.
Data Field	**Nutritional Screening**
Nutritional Screening	Check all boxes that apply and complete requested details that represent the Individual's nutritional status. If none reported, check "No Problem" and skip to next section.

Data Field	Pain Screening
Does pain currently interfere with your daily activities?	If yes, indicate the degree to which pain interferes with Individual's activities.
Please indicate the source of pain	Identify where the pain is located and the source, (e.g., back pain due to sciatica)
If completed by individual/ family/guardian, please sign and date below	The Individual who completed the form prints their name, specifies relationship to individual, and signs and dates their signature in the designated places. For example, in a mental health clinic this form will serve as a screening tool that is self-administered. In such cases, the Individual filling it out would print and sign their name and include the date that the form is being completed.
Data Field	**Actions, Recommendations and Referrals by Medical Reviewer:**
Actions, Recommendations and Referrals by Medical Reviewer:	This section is to be completed by qualified medical personnel upon their review of the form after it is completed by the individual, family, or guardian. If this form is not completed by the individual, family or guardian (for example, a medical professional would complete the assessment with the individual in a PROS or OASAS program) then this portion would be completed after the previous sections are assessed.
Was Assessment completed face-to-face?	Check the appropriate box to indicate if the reviewer met with the Individual face-to-face, or not. For example, if this form was utilized as a screening tool in a mental health clinic, you would check *No*. In such a case, the medical professional would only be reviewing what was filled out by the Individual, family or guardian.
Specify Action(s)Taken	Check the appropriate boxes to indicate actions taken. If no blood work is ordered, indicate why not. If blood pressure is taken, record the results.
Required For PROS With Clinic	For PROS Programs that provide clinic treatment, additional health information is required. Include the following: Blood pressure, Abdominal girth, Body Mass index (BMI), Temperature, Pulse, and Respiration. Additionally, specify whether the Individual has a health care proxy or advanced directive in place. Although this information is not required for other programs at this time, it is recommended that this information be captured.
Recommendations or Referrals made	Check all applicable referrals made or the box for "No referrals made". For each referral made, provide details of the referral (e.g. reason for referral and who referral was made to)
Comments	Additional information related to recommendations and referrals can be entered in this section.
Data Field	**Recommendation Shared with Individual Served**
Recommendation Shared with Individual Served	Check yes or no. If yes, record the Individual's response to recommendations. If no, indicate how recommendations will be shared with the Individual served.
Data Field	**Medical Reviewer Signature**
Reviewed/Completed By-Print Name, Credentials, Signature, Date	Provide printed name, credentials, legible signature, and the date reviewed for the medical reviewer of this questionnaire.