Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Part A
Brief Medical Screening

Doctor's Name:	Address:	Phone Number:	**Date of Last Exam**:
Dentist's Name:	Address:	Phone Number:	**Date of Last Exam**:

Has a Doctor EVER told you that you had any of the following conditions?				
Condition	**Check One**		**Currently Under a Doctor's Care**	**Comment**
	Now	Past		
Alzheimer's Disease or Dementia	☐	☐	☐ No ☐ Yes	
Blood Sugar-High	☐	☐	☐ No ☐ Yes	
Blood Pressure (High)	☐	☐	☐ No ☐ Yes	
Cancer	☐	☐	☐ No ☐ Yes	
Deafness or other hearing impairment	☐	☐	☐ No ☐ Yes	
Diabetes	☐	☐	☐ No ☐ Yes	
Endocrine Condition (High or Low thyroid, Pituitary or Adrenal Disease)	☐	☐	☐ No ☐ Yes	
Epilepsy/Seizures	☐	☐	☐ No ☐ Yes	
Heart Attack	☐	☐	☐ No ☐ Yes	
Hyperlipidemia (High blood fat/Cholesterol and/or Trigycerides)	☐	☐	☐ No ☐ Yes	
Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis	☐	☐	☐ No ☐ Yes	
Kidney Disease	☐	☐	☐ No ☐ Yes	
Liver Disease ((Cirrhosis), Hepatitis A/B/C))	☐	☐	☐ No ☐ Yes	
Mobility Impairment	☐	☐	☐ No ☐ Yes	
Other Cardiac Condition	☐	☐	☐ No ☐ Yes	
Progressive neurological condition (Multiple Sclerosis (MS), Cerebral palsy, Amyotrophic Lateral Sclerosis (ALS))	☐	☐	☐ No ☐ Yes	
Pulmonary (Emphysema (Chronic Pulmonary Disease (COPD), Asthma)	☐	☐	☐ No ☐ Yes	
Sexually Transmitted or other Communicable Disease (for example, Herpes, Human Immunodeficiency Virus (HIV), History of active tuberculosis)	☐	☐	☐ No ☐ Yes	
Sight Impairment	☐	☐	☐ No ☐ Yes	
Speech Impairment	☐	☐	☐ No ☐ Yes	
Stroke	☐	☐	☐ No ☐ Yes	
Traumatic Brain Injury	☐	☐	☐ No ☐ Yes	
Weight (Obesity, Unexplained Gain or Loss)	☐	☐	☐ No ☐ Yes	
Other physical related health conditions	☐	☐	☐ No ☐ Yes	

Organization Name:	**Program Name:**	**Date:**
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CURRENT Medication Information ☐ **None**
(Include all current medication-Psychiatric/Non-Psychiatric, Prescription/Over-the-counter drugs/Herbal)

Medication	Reason for Taking	Dosage/Frequency and When taken (Dates/Length of time)	Side-effects	Helpful?	Prescriber
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	

Additional:

Medication HISTORY Information ☐ **None**
(As best as possible, list all additional medications taken for psychiatric or substance abuse issues in the past)

Medication	Reason for Taking	Dosage/Frequency and When taken (Dates/Length of time)	Side-effects	Helpful?	Prescriber
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	

Additional - Are there any medications you would like to avoid taking in the future?:

Allergies/Drug Sensitivities ☐ None

☐ Food (specify):

☐ Medicine (specify):

☐ Latex / ☐ Other (specify):

Medical hospitalizations/significant operative and invasive procedures?
☐ No ☐ Yes If yes, complete information below:

Hospital	Date	Reason

Comments:

Organization Name:	**Program Name:**	**Date:**
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Nutrition/Hydration Screening Check if you have experienced:

1. ☐ **Any weight loss or gain of 10 pounds or more in the past three months**
2. ☐ **Change in appetite**
3. ☐ **Are you experiencing any other problems eating or drinking?**

The Joint Commission

Pain Screening

Do you have any ongoing pain problems? ☐ No ☐ Yes If yes, Medical Staff completes pain section below.

For Women Only

Currently pregnant?

☐ No ☐ Yes - If yes, expected delivery date:

Receiving pre-natal healthcare?

☐ No ☐ Yes – If yes, indicate provider:

Are you currently breastfeeding? ☐ No ☐ Yes

Any significant pregnancy history?

☐ No ☐ Yes – If yes, explain:

Menstruation

Last menstrual Period Date:

Pre-menstrual symptoms: ☐ No ☐ Yes

Menstrual Pain: ☐ No ☐ Yes

Polycystic Ovary Syndrome? ☐ No ☐ Yes

Menstrual Irregularities: ☐ No ☐ Yes ☐ Other:

If yes, Indicate provider:

For Children Only

Immunizations: Has the child or adolescent been immunized for the following diseases? Please check all that apply.

☐ Chicken Pox ☐ Diphtheria ☐ German Measles (rubella) ☐ Hepatitis B ☐ Measles ☐ Mumps

☐ Polio ☐ Small Pox ☐ Tetanus ☐ Other:

All immunizations up to date? ☐ Yes ☐ No – Comments:
Prenatal exposure to Alcohol or other Drugs? ☐ Yes ☐ No – Comments:
Any other significant information that may affect care or place the child or adolescent at risk (for example, accidents or injuries):

Completed By - Print Name:	**Signature:**	**Date:**

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Part B. Medical Assessment – (To be completed by Medical Staff/Reviewer)

Vital Signs/Physical Health Indicators
(Required, Where Indicated, For PROS W/CLINIC & Vitals Required for COA Opioid and Strongly Recommended for Others)

Blood Pressure:	**Abdominal girth:**	**Temperature:**	**Pulse:**
Respiration:	**Height:**	**Weight:**	**BMI:**

Nutritional/Hydration Status

If individual answered yes to any of the items in Nutrition/Hydration Screening above, provide referral information below or rationale if no further action taken:

Does individual have any medical concerns that may interfere with treatment or for which s/he needs assistance? ☐ No ☐ Yes
If Yes, explain:

Pain Assessment

Individual has pain based on Pain Screen section above: ☐ No ☐ Yes If yes, complete:

Site #1	**Site #2**
Location:	Location:
Description:	Description:

Pain is adequately controlled: ☐ No ☐ Yes
If no, is individual under medical care: ☐ No ☐ Yes - ***If no, make referral and document below:***

Actions Taken

OASAS

For those between the ages of 13 and 64: If HIV Test was negative, has the medical provider offered an HIV test? ☐ No ☐ Yes If no, explain:

Did the undersigned check the Prescription Drug Monitoring Program (PDMP) for this individual?
☐ No ☐ Yes If no, provide reason:

Physical Exam Information

OASAS

☐ No Physical Exam within the past 12 months; within 45 Days the individual will:
- ☐ Have a physical exam ***[Residential-Attach Copy]***; or
- ☐ Have a face-to-face assessment by a medical staff member to determine the need for a physical exam ***[Outpatient-See Referral Section Below]***; or
- ☐ Be referred for a physical examination ***[Outpatient-Complete Referral Information Below].***

☐ Physical Exam within the past 12 months or admitted directly to the service of another OASAS-certified service; the medical history and physical examination (including required laboratory tests) from such other services or physicians, (dated:) has been reviewed and determined to be current and accurate by:

- ☐ clinical or medical staff member ***[Residential Signature & Credentials: Date:]; or***
- ☐ medical staff member **[Outpatient *Signature & Credentials:* *Date:* *].***

Organization Name:	**Program Name:**	**Date:**
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The Joint Commission

Was Last physical completed more than one year ago? ☐ No ☐ Yes - If Yes, document referral below:

Referrals and Recommendations

OASAS

Based on Face to Face Medical Assessment:

☐ **Individual requires physical exam- see referral below, OR**

☐ **Individual does not require physical exam**

☐ Nutrition/Hydration Referral:
☐ Pain Referral:
☐ Specialty Care:

☐ Primary Care Physician (General Referral):
☐ Primary Care Physician for Physical Exam and Date, if known:

☐ Other:

Comments, if indicated:

Completed By - Print Staff Name/Credentials:	**Staff Signature:**	**Date:**