| 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 |       |
|  |
|  |
| **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:**  |
|  |
| **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:     **Are you currently breastfeeding?** [ ]  No [ ]  Yes | **Receiving pre-natal healthcare?** [ ]  No [ ]  Yes – If yes, indicate provider:      **Any significant pregnancy history?**[ ]  No [ ]  Yes – If yes, explain:       |
| **Menstruation****Last menstrual Period Date**:       **Menstrual Pain:** [ ]  No [ ]  Yes**Menstrual Irregularities:** [ ]  No [ ]  Yes [ ]  Other:       | **Pre-menstrual symptoms:** [ ]  No [ ]  Yes**Polycystic Ovary Syndrome?** [ ]  No [ ]  Yes 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:**      |
| **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 [ ]  YesIf 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** **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:***      ***].*** |
| **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:** |