

Comprehensive Health Assessment Form

40 to 49 Years: Female at Birth	Actual Age: _____	Date: _____
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____	
Intake	Vital Signs	
Allergies / Reaction	Temp	
Height	BP	
Weight <input type="checkbox"/> Significant loss/gain: _____ lbs	Pulse	
BMI Value	Resp	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable		
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Advance Directive Info Given/Discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> HTN <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> STI <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____		
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List <input type="checkbox"/> taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)		
Education (last grade completed): _____ Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other: _____		
Interval History		
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Low calorie <input type="checkbox"/> ADA <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____	
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
LMP:	G P A	<input type="checkbox"/> Menorrhagia <input type="checkbox"/> Menopause
Hysterectomy	<input type="checkbox"/> Partial <input type="checkbox"/> Total	
Sexually active	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Multiple Partners	
Contraceptive Used	<input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____	
Intimate Partner Violence	In the last 12 months: Has anyone physically hurt you? <input type="checkbox"/> Yes <input type="checkbox"/> No Has anyone insulted or humiliated you? <input type="checkbox"/> Yes <input type="checkbox"/> No Has anyone threatened you? <input type="checkbox"/> Yes <input type="checkbox"/> No Has anyone screamed or cursed at you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Last PAP/HPV	Date: _____	<input type="checkbox"/> WNL
Last Mammogram	Date: _____	<input type="checkbox"/> WNL
Last Colonoscopy	Date: _____	<input type="checkbox"/> WNL

Name: _____		DOB: _____		MR#: _____	
Social Determinants of Health (SDOH)		<input type="checkbox"/> Unremarkable for social drivers of health <input type="checkbox"/> Changes since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment, transportation <input type="checkbox"/> Stressors (mental illness, alcohol/drugs, violence/abuse)			
Current Alcohol / Substance Use		<input type="checkbox"/> None <input type="checkbox"/> Alcohol			
<input type="checkbox"/> Drugs (specify): _____		<input type="checkbox"/> IV Drugs-Current <input type="checkbox"/> IV Drugs-Past Hx		<input type="checkbox"/> Other: _____	
Family History		<input type="checkbox"/> None <input type="checkbox"/> Diabetes			
<input type="checkbox"/> Heart disease / HTN		<input type="checkbox"/> Lives/lived with someone HBV+		<input type="checkbox"/> Hip fracture	
<input type="checkbox"/> High cholesterol		<input type="checkbox"/> Cancer		<input type="checkbox"/> Other: _____	
Immunization History / Date		<input type="checkbox"/> None <input type="checkbox"/> See CAIR			
<input type="checkbox"/> COVID #1: <input type="checkbox"/> COVID #2:		<input type="checkbox"/> Influenza:		<input type="checkbox"/> Tdap:	
<input type="checkbox"/> COVID Booster(s):		<input type="checkbox"/> MMR:		<input type="checkbox"/> Varicella: <input type="checkbox"/> Exempt (DOB < 1980 & non-healthcare worker)	
<input type="checkbox"/> Hepatitis B:		<input type="checkbox"/> Pneumococcal:		<input type="checkbox"/> Other: _____	
USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)		
Alcohol Misuse Score: _____	<input type="checkbox"/> TAPS , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Breast Cancer (Starting at 40 yrs old)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Cervical Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Colorectal Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Depression Score: _____	<input type="checkbox"/> PHQ2 , <input type="checkbox"/> PHQ9 , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Drug Misuse Score: _____	<input type="checkbox"/> TAPS , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Intimate Partner Violence	<input type="checkbox"/> SDOH , <input type="checkbox"/> HITS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Member Risk Assessment	<input type="checkbox"/> SDOH , <input type="checkbox"/> ACEs , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Obesity	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Osteoporosis	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Sexually Transmitted Infections	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Tobacco Use	<input type="checkbox"/> SHA , <input type="checkbox"/> TAPS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Screener , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Physical Examination				WNL	
General appearance		Well-nourished & developed No abuse/neglect evident		<input type="checkbox"/>	
Head		No lesions		<input type="checkbox"/>	

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Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	<input type="checkbox"/>
Ears	Canals clear, TMs normal Hearing grossly normal	<input type="checkbox"/>
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>
Mouth / Gums	Pink, no bleeding/inflammation/lesions	<input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>
Chest / Breast	Symmetrical, no masses	<input type="checkbox"/>
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>
Genitalia	Grossly normal	<input type="checkbox"/>
Female	No lesions, normal external appearance	<input type="checkbox"/>
Vaginal exam	Done or completed elsewhere OB/GYN name:	<input type="checkbox"/>
Femoral pulses	Present & equal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician / Nutritionist
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Other:	
Orders		
<input type="checkbox"/> COVID 19 vaccine / booster	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Hep C Antibody test (if high risk)	<input type="checkbox"/> Hct / Hgb <input type="checkbox"/> Lipid panel
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> HIV (if high risk) <input type="checkbox"/> Herpes	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> Pneumococcal (if high risk)	<input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomonas	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Tdap	<input type="checkbox"/> Rx for folic acid 0.4- 0.8mg daily	<input type="checkbox"/> Fasting plasma glucose <input type="checkbox"/> Oral glucose tolerance
<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> gFOBT or Fit <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> HbA1C <input type="checkbox"/> Low to moderate dose statin

Name: _____ **DOB:** _____ **MR#:** _____

<input type="checkbox"/> Zoster (if high risk)	<input type="checkbox"/> PAP	<input type="checkbox"/> Bone Density Test
	<input type="checkbox"/> HPV	<input type="checkbox"/> Mammogram
<input type="checkbox"/> Other:		
Anticipatory Guidance (AG) / Education (✓ if discussed)		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Eating disorder
Accident Prevention & Guidance		
<input type="checkbox"/> Alcohol/drug/substance misuse counseling	<input type="checkbox"/> Avoid risk-taking behavior	<input type="checkbox"/> Independence
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Personal development
<input type="checkbox"/> Mental health (emotional support)	<input type="checkbox"/> Violent behavior	<input type="checkbox"/> Goals in life
<input type="checkbox"/> Diabetes management	<input type="checkbox"/> Mindful of daily movements	<input type="checkbox"/> Work activities
<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Motor vehicle safety (DUI / no texting & driving)	<input type="checkbox"/> Family support, social interaction & communication
<input type="checkbox"/> Sex education (partner selection)	<input type="checkbox"/> Seat belt	<input type="checkbox"/> Self-breast exam
<input type="checkbox"/> Safe sex practices (condoms, contraception, HIV/AIDS)	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Aging process
<input type="checkbox"/> Smoking/vaping use/exposure	<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Perimenopause education
Tobacco Use / Cessation		
<input type="checkbox"/> Never smoked or used tobacco products		
<input type="checkbox"/> Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____		
<input type="checkbox"/> Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____		
Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other:		
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discussed smoking cessation medication	<input type="checkbox"/> Discussed smoking cessation strategies
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	<input type="checkbox"/> Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)
<input type="checkbox"/> Member refused the following screening/orders: