For efficient health management.

PreventivePLUS
Health Management

Health Management Audit

Be with one of the most successful companies in the last years. Find out what is the different between us and our market competitors.

Health Examination

QUESTIONNAIRE FOR HEALTH EXAMINATION

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Company Representative
Jeffery Liva

MEDICAL EXAMINATION TABLE OF CONTENTS.

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INTRODUCTION TO YOUR HEALTH 01

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PREVENTIVE PLUS HEALTH SURVEILLANCE FORM

Medical Screening and Health Surveillance are two fundamental strategies for optimizing a person's health. Although the terms are often used interchangeably, they are quite distinct concepts. Medical screening is, in essence, only one component of a comprehensive Health Surveillance program.

The fundamental purpose of screening is early diagnosis and treatment of the individual and thus has a clinical focus.

The fundamental purpose of surveillance is to detect and eliminate the underlying causes such as hazards or exposures of any discovered trends and thus has a prevention focus.

Both can contribute significantly to the success of one's health and managing the appropriate intervention programs. However The Preventive Plus "Health Surveillance" requirements are generally clinically focused (e.g.,medical and work histories, physical assessment, biological testing) with information obtained from the clinical processes used in the monitoring and analysis elements of Health Surveillance.

Preventive Plus's Medical Screening and Health Surveillance Program are based on the judicious use of the best current available scientific research in making decisions and recommendations concerning the individual management of patients.

Jeffery S Liva
M.D., M.P.H., M.S.
PreventivePLUS

Your Information

Name

Date of Birth

Address

Suburb / City

State

Zip Code

Home Phone

Cell Phone

Business Phone

Email Address

Emergency Contact Name

Emergency Contact Number

Marital Status

- [ ] Married
- [ ] Single
- [ ] Separated
- [ ] Divorced
- [ ] Widowed

Ethnicity

- [ ] Caucasian
- [ ] African American
- [ ] Hispanic
- [ ] Asian
- [ ] Indian
- [ ] Other

Other information:

PreventivePLUS Health Management

About Your Primary Care

Primary Care Physician Name

Address

City / Postal Code

Phone

Mobile

Fax

Email Address

Medical History Source

- [ ] Self
- [ ] Spouse
- [ ] Partner
- [ ] Family
- [ ] Medical Records
- [ ] Other

Other information:

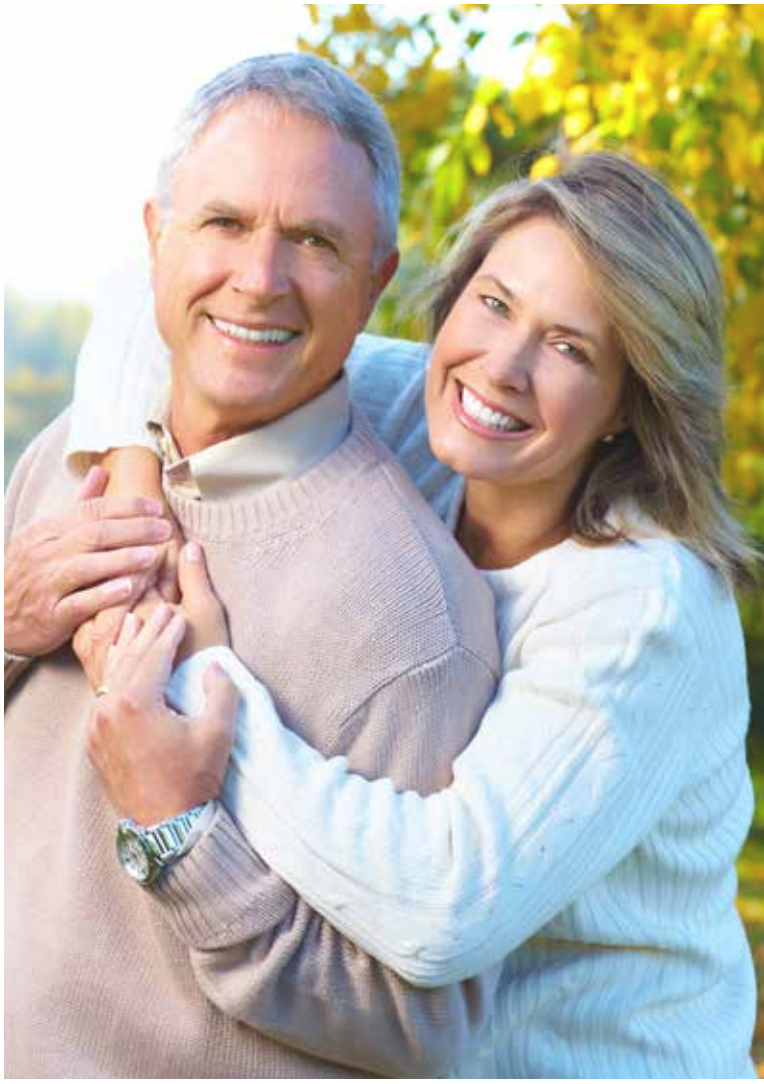
Handiness

- [ ] Left Handed
- [ ] Right Handed
- [ ] Ambidextrous

Reason For Visit

- [ ] Health Examination or Goals
- [ ] Health issue(s) or problem(s)

Please describe or express the reason for todays visit:



Obtaining An Accurate History Is The Critical First Step In Determining The Source Of A Your Problem.

By providing an accurate previous health history, this will in most cases enable us to make a diagnosis based on this history.

Please Note: If you have no current health issues, then please skip this section.

YOUR CURRENT HEALTH CONCERNS 02

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About Your Pain & Symptoms

Pain or symptoms is located in the:

Radiates to:

What is The Pain or Symptom Like?

- [ ] Dull
- [ ] Heavy
- [ ] Pressure
- [ ] Sharp
- [ ] Stabbing
- [ ] Electrical
- [ ] Pins & needles
- [ ] Numbness
- [ ] Burning
- [ ] Throbbing
- [ ] Pounding
- [ ] Aching

Other:

How Bad Is The Problem?

How bad is the problem?:

Severity of Pain:

0 is no pain & 10 is severe pain:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please describe how your injury occurred or the onset of your illness:

When did it start?

How long does it last?

How often does it come?

Please Describe How Your Injury Occurred Or The Onset Of Your Illness:

When did it start?

How long does it last?

How often does it come?

Is There An Association With:

- [ ] Home
- [ ] Work
- [ ] Personal
- [ ] Activities
- [ ] Emotional Reactions
- [ ] Other

What Makes The Problem Better?

- [ ] Activity
- [ ] Rest
- [ ] Sleep
- [ ] Lying Still
- [ ] Lying Down
- [ ] Walking
- [ ] Standing
- [ ] Sitting
- [ ] Medications
- [ ] Injections
- [ ] Heat
- [ ] Cold
- [ ] Physical Therapy
- [ ] Acupuncture
- [ ] Chiropractic Manipulation
- [ ] Other

What Makes The Problem Worse?

- [ ] Activity
- [ ] Rest
- [ ] Sleep
- [ ] Lying Still
- [ ] Lying Down
- [ ] Walking
- [ ] Standing
- [ ] Sitting
- [ ] Medications
- [ ] Injections
- [ ] Heat
- [ ] Cold
- [ ] Physical Therapy
- [ ] Acupuncture
- [ ] Chiropractic Manipulation
- [ ] Other

If other, please describe:

Is There An Association With:

☐ Yes ☐ No ☐ Not Sure

If yes, please describe:

What did you do following the injury or the onset of symptoms?

Please describe:

Briefly describe what has occurred since that time to this date:

Please describe:

Are there other symptoms associated with the chief complaint?

Please describe:

Is This Injury or Illness Work Related?

☐ Yes ☐ No ☐ Not Sure

If yes, please describe:

The History Provides A Database On Which A Diagnosis, A Plan For Management Of The Diagnosis, Treatment, Care, And Follow-Up Observation Of The Patient May Be Made.

Please Note: If you have no current or past health issues, then please skip this section.

YOUR PREVIOUS MEDICAL ISSUES 03

PreventivePLUS Health Management

List Your Medications

	Medication Name	Route	Form	Strength
1				
2				
3				
4				
5				
6				
7				
8				
9				

List Your Allergies

	Allergy	Reaction Date	Reaction	Type
1				
2				
3				
4				
5				

Past Medical History

- [ ] Anemia
- [ ] Anxiety
- [ ] Arrhythmia
- [ ] Arthritis
- [ ] Asthma
- [ ] Back Pain
- [ ] Brain Injury
- [ ] Cancer
- [ ] Chronic Bronchitis
- [ ] Chronic Pain
- [ ] Cirrhosis
- [ ] Depression
- [ ] Diabetes
- [ ] Drop Foot
- [ ] Emphysema
- [ ] Gastric Reflux
- [ ] Gout
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] High Cholesterol
- [ ] Hypertension
- [ ] Hypothyroid
- [ ] Incontinence
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Menopause
- [ ] Nervous Disorder
- [ ] Osteoporosis
- [ ] Paralysis
- [ ] Peripheral Arterial Disease
- [ ] Phlebitis
- [ ] Stroke/TIA
- [ ] Ulcer
- [ ] Other

Other:

Past Medical or Health Condition(s)

	Medical or Health Condition(s)	Date Started	Date Resolved
1			
2			
3			
4			
5			
6			
7			
8			
9			

List Past Surgical History

- ☐ Appendectomy
- ☐ C- Section
- ☐ Cataract Surgery
- ☐ Colectomy
- ☐ Create Eardrum Opening
- ☐ Diagnostic laryngoscopy
- ☐ Back Surgery
- ☐ Hysterectomy
- ☐ Removal of Gallbladder
- ☐ Kidney Surgery
- ☐ Bladder Surgery
- ☐ Colonoscopy
- ☐ Sinus Surgery
- ☐ Re-constructive Surgery
- ☐ Other

Other:

Past Surgical History

	Name of Surgery/Procedure	Procedure Date	Location	Comment(s)
1				
2				
3				
4				
5				

Other information:

Hospitalizations

	Hospital	Purpose	Admit Date	Discharge Date	Comment(s)
1					
2					
3					
4					
5					

Other information:

Your Overall Well-Being As A Person Is Dependant Upon Many Factors...

The overall well-being of the person is dependent on the individual responsibility for initiating activities in many different area of health including engaging in healthy eating, regular exercise, sufficient sleep & a positive mindset.

YOUR LIFESTYLE 04

Anxiety & Depression PHQ-4

Over the last 2 weeks, how often have you been bothered by the following problems?

Tick to indicate your answer:	Not at all	Several days	More than 1/2 the days	Nearly every-day
Feeling nervous, anxious or on edge	☐ 0	☐ 1	☐ 2	☐ 3
Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3

Eating Patterns (STC)

Over the past 7 days:

Tick to indicate your answer:	Less Than 1 Time	1-3 Times	4 or more times
How many times a week did you eat fast food / snacks or pizza?	☐ 0	☐ 2	☐ 3
How many soda and sugar sweetened drinks (regular, not diet) did you drink each day?	☐ 0	☐ 2	☐ 3

Physical Activity

1. How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?

Number of days:

2. On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise at this level?

Number of minutes:

Quality of Life

In general would you say your health is:

- [ ] Excellent
- [ ] Very Good
- [ ] Good
- [ ] Fair
- [ ] Poor

Risky Drinking

1. How many times in the past year have you had X or more drinks in a day? (Where X is 5 for men and 4 for women,)

a. How often do you have a drink containing alcohol?

- [ ] Never
- [ ] Monthly or less
- [ ] 2-4 times a month
- [ ] 4 or more times a week
- [ ]

b. How many standard drinks containing alcohol do you have on a typical day?

- [ ] None
- [ ] 1 or 2
- [ ] 3 or 4
- [ ] 5 or 6
- [ ] 7 to 9
- [ ] 10 or more

c. How often do you have six or more drinks on one occasion?

- [ ] Never
- [ ] Daily
- [ ] Almost Daily
- [ ] Weekly
- [ ] Less than Monthly
- [ ] Monthly

Sleep Quality

1. Do you snore or has anyone told you that you snore?

2. In the past 7 days, I was sleepy during the daytime:

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Stress

1. Please rate with a number from (0-10) that best describes how much distress you have been experiencing in the past week including today.

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10

Please rate the extent to which the following common sources contributed to your overall stress in the last week:

Financial	☐	Not at all	☐	Very little	☐	Somewhat	☐	Quite a bit	☐ Greatly
Social	☐	Not at all	☐	Very little	☐	Somewhat	☐	Quite a bit	☐ Greatly
Family	☐	Not at all	☐	Very little	☐	Somewhat	☐	Quite a bit	☐ Greatly
Work	☐	Not at all	☐	Very little	☐	Somewhat	☐	Quite a bit	☐ Greatly
Health	☐	Not at all	☐	Very little	☐	Somewhat	☐	Quite a bit	☐ Greatly
Other	☐	Not at all	☐	Very little	☐	Somewhat	☐	Quite a bit	☐ Greatly

Substance Use

1. How many times in the past year have you used an illegal drug or a prescription medication for non-medical reasons?

- [ ] Never
- [ ] Rarely
- [ ] Sometimes
- [ ] Often
- [ ] Always

Tobacco Use

1. Have you used tobacco in the last 30 days?

a. Smoked Cigarettes:

- [ ] Yes
- [ ] No

b. Used a Smokeless Tobacco Product:

- [ ] Yes
- [ ] No

2. For all who responded YES to having smoked or used smokeless tobacco in the last 30 days:

a. Would you be interested in quitting tobacco use within the next few weeks?

- [ ] Yes
- [ ] No

Medication Reconciliation

Many patients have good reasons for not taking their prescribed medications.

1. On how many days over the past week did you miss taking one or more of your medications?

- [ ] 0 (none)
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7 (every day)

In Some Cases, Work Can Cause Illness And Illness Can Affect The Capacity To Do Work .

The ability of a worker to function at an optimum level of well-being at a work-site as reflected in terms of productivity, work attendance, disability compensation claims, and employment longevity.

Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier

Please Note: If you have never worked , then please skip this section.

YOUR OCCUPATIONAL PROFILE 05

Work History / Occupational Profile

The following questions refer to your current or most recent job:

Job title:

Describe this job:

Name of employer:

Type of industry: Date job began:

Are you still working in this job? ☐ Yes ☐ No

If no, when did this job end?:

Occupational Exposure Inventory

1. Have you ever been off work for more than 1 day because of an illness related to work?

2. Have you ever been advised to change jobs or work assignments because of any health problems or injuries?

3. Has your work routine changed recently?

4. Is there poor ventilation in your workplace?

Have you worked in any of the following industries?

- ☐ Chemical Laboratory
- ☐ Chemical Plant
- ☐ Coke Oven
- ☐ Construction
- ☐ Widowed
- ☐ Cotton, Flax or Hemp Mill
- ☐ Farming
- ☐ Foundry
- ☐ Hazardous Waste Industry
- ☐ Healthcare
- ☐ Lumber mill
- ☐ Mine
- ☐ Nuclear Industry
- ☐ Paper Mill
- ☐ Pharmaceutical Industry
- ☐ Plastic Production
- ☐ Refinery
- ☐ Rubber Plant Processing
- ☐ Construction
- ☐ Sand Pit or Quarry
- ☐ Service Station
- ☐ Shipyard
- ☐ Smelter
- ☐ Waste Industry
- ☐ Other

Fill in the table below listing all jobs you have worked including short-term, seasonal, part-time employment, and military service. Begin with you most recent job. Use additional paper if necessary.

Employment History

	Date	Job Title & Description of Work	Exposures*	Protective Equipment
1				
2				
3				
4				
5				
6				
7				
8				

*List the chemicals, dusts, fibers, fumes, radiation, biologic agents (i.e., molds or viruses) and physical agents (i.e., extreme heat, cold, vibration, noise) that you were exposed to at this job

Environmental Exposures

Have you ever worked at a job or hobby in which you came in contact with any of the following by breathing, touching, or ingesting (swallowing)?

If you have and know the specific substance(s), please check the box beside the substance. If you only know the group and are unsure of the specific substance, check the box beside the group name:

1. Aerosols, vapors, gases

- ☐ Acetylene
- ☐ Carbon monoxide(CO)
- ☐ Ethylene oxide
- ☐ Formaldehyde
- ☐ Halo-thane
- ☐ Hydrogen cyanide
- ☐ Hydrogen-sulfide
- ☐ Nitrogen Oxide/dioxide
- ☐ Hazardous Waste Industry
- ☐ Phosgene
- ☐ Sewer gas
- ☐ Smoke
- ☐ Sulfur Dioxide
- ☐ Nuclear Industry
- ☐ Paper Mill

2. Biological Agents

- ☐ Bacteria
- ☐ Fungi
- ☐ Mold
- ☐ Spores

3. Corrosive substances & Inorganic Gases

- ☐ Ammonias
- ☐ Alkalies
- ☐ Chlorine
- ☐ Hydrochloric acid

4. Inorganic Dust & Powders

- ☐ Asbestos
- ☐ Coal Dust
- ☐ Fiberglass
- ☐ Fluoride
- ☐ Silica
- ☐ Talc

5. Insecticides, Herbicides, Pesticides

- ☐ Carbonates
- ☐ Chlorophenoxy herbicides (Dioxin)
- ☐ Ethylene dibromide
- ☐ Ethylene dichloride
- ☐ Organochlorine
- ☐ DDT
- ☐ Aldrin
- ☐ Endrin
- ☐ Dieldrin
- ☐ Chlordane
- ☐ Lindane
- ☐ Penta-chlorophenol (PCP)
- ☐ Organophosphates
- ☐ Parathion
- ☐ Malathion
- ☐ Diazinon
- ☐ Fungicides

6. Metals & Metal Fumes

- ☐ Aluminum (Al)
- ☐ Arsenic (As)or Argine
- ☐ Antimony (Sb)
- ☐ Beryllium (Be)
- ☐ Cadmium (Cd)
- ☐ Chromium (Cr)
- ☐ Cobalt (Co)
- ☐ Copper (Cu)
- ☐ Iron (Fe)
- ☐ Lead (Pb)
- ☐ Magnesium (Mg)
- ☐ Manganese (Mn)
- ☐ Mercury (Hg)
- ☐ Nickel (Ni)
- ☐ Platinum (Pt)
- ☐ Selenium (Se)
- ☐ Silver (Si)
- ☐ Strontium (Sr)
- ☐ Tin (Sn)
- ☐ Uranium (U)
- ☐ Vanadium (V)
- ☐ Zinc (Zn)
- ☐ Welding fumes

7. Petrochemicals, Oils

- ☐ Asphalt & tar
- ☐ Coal tar
- ☐ Naphthalene
- ☐ Mineral Oils
- ☐ PAH's Polycyclic Aromatic Hydrocarbons
- ☐ Petroleum distillates
- ☐ Polybrominated biphenyls PBB
- ☐ Polychlorinated biphenyls PCB

8. Physical Agents

- [ ] Heavy lifting
- [ ] Noise
- [ ] Heat stress
- [ ] Cold stress
- [ ] Vibration
- [ ] Repetitive Trauma
- [ ] Stress in the workplace
- [ ] Vegetable Matter

9. Organic Compounds in Rubbers, Plastics & Synthetic Textiles

- [ ] Vinyl Chloride
- [ ] Fluorocarbons
- [ ] Epoxy resins
- [ ] Acrylonitrile
- [ ] Styrene
- [ ] Plastics
- [ ] Natural & Synthetic Rubber
- [ ] Synthetic Textiles

10. Organic Nitrogen Compounds

- [ ] Aromatic Nitro Compounds
- [ ] Nitrates
- [ ] Nitrites

11. Radiation

- [ ] Radioactive materials
- [ ] Microwaves
- [ ] Ultraviolet rays
- [ ] X-rays
- [ ] Uranium
- [ ] Radon
- [ ] Other

12. Solvents

- [ ] Benzene,Toluene,Xylene
- [ ] Carbon disulfide
- [ ] Carbon Tetrachloride
- [ ] Chloroform
- [ ] Glycol ethers
- [ ] Formaldehyde
- [ ] Paints,Varnishes,Degreasers
- [ ] Ketones
- [ ] Methylene Chloride
- [ ] Tetrachloroethylene (TCE)
- [ ] Tetrachloroethylene
- [ ] Other

13. Sensitizing Agents

- [ ] Isocyanates
- [ ] Diisocyanates
- [ ] Nickel
- [ ] Platinum
- [ ] Proteolytic enzymes
- [ ] Aliphatic amines
- [ ] Poison ivy, oak, sumac
- [ ] Bee stings

14. Miscellaneous

- [ ] Hydrazine's
- [ ] Nonspecific dust exposure
- [ ] Picric acid
- [ ] TNT

Your Exposure History

1. Are you currently exposed to any of the following?

- [ ] Metals
- [ ] Fumes
- [ ] Dust or fibers
- [ ] Radiation
- [ ] Chemicals
- [ ] Loud noise
- [ ] Vibration
- [ ] Heat Intolerance
- [ ] Cold Intolerance
- [ ] Biologic Agents

2. Have you been exposed to any of the above in the past?

- [ ] Yes
- [ ] No

3. Do any household members have contact with metals, dust, fibers, chemicals, fumes, radiation, or biologic agents?

☐ Yes ☐ No

If you answered yes to any of the items above, describe your exposure in detail - to what extent (how much) you were exposed if you know. If you need more space, please use a separate sheet of paper.

Exposure Information

How you were exposed?	What you were exposed to?	How much?	When?

4. Do you know the names of the metals, dusts, fibers, chemicals, fumes, or radiation that you are/were exposed

☐ Yes ☐ No

If yes, list them here:

5. Do you get the material on your skin or clothing?

☐ Yes ☐ No

6. Are your work clothes laundered at home?

☐ Yes ☐ No

7. Do you shower at work?

☐ Yes ☐ No

8. Can you smell the chemical or material you are working with?

☐ Yes ☐ No

9. Do you use protective equipment such as gloves, masks, respirator, hearing protectors?

☐ Yes ☐ No

If yes, list them here:

10. Have you been advised to use protective equipment?

☐ Yes ☐ No

11. Have you been instructed in the use of protective equipment?

☐ Yes ☐ No

12. Do you wash your hands with solvents?

☐ Yes ☐ No

13. Do you smoke at the workplace?

☐ Yes ☐ No

14. Are you exposed to secondhand tobacco smoke at the workplace?

☐ Yes ☐ No

At home:

☐ Yes ☐ No

15. Do you eat at the workplace?

☐ Yes ☐ No

16. Do you know of any coworkers experiencing similar or unusual symptoms?

☐ Yes ☐ No

17. Are family members experiencing similar or un-usual symptoms?

☐ Yes ☐ No

18. Has there been a change in the health or behavior of family pets?

☐ Yes ☐ No

19. Do your symptoms seem to be aggravated by a specific activity?

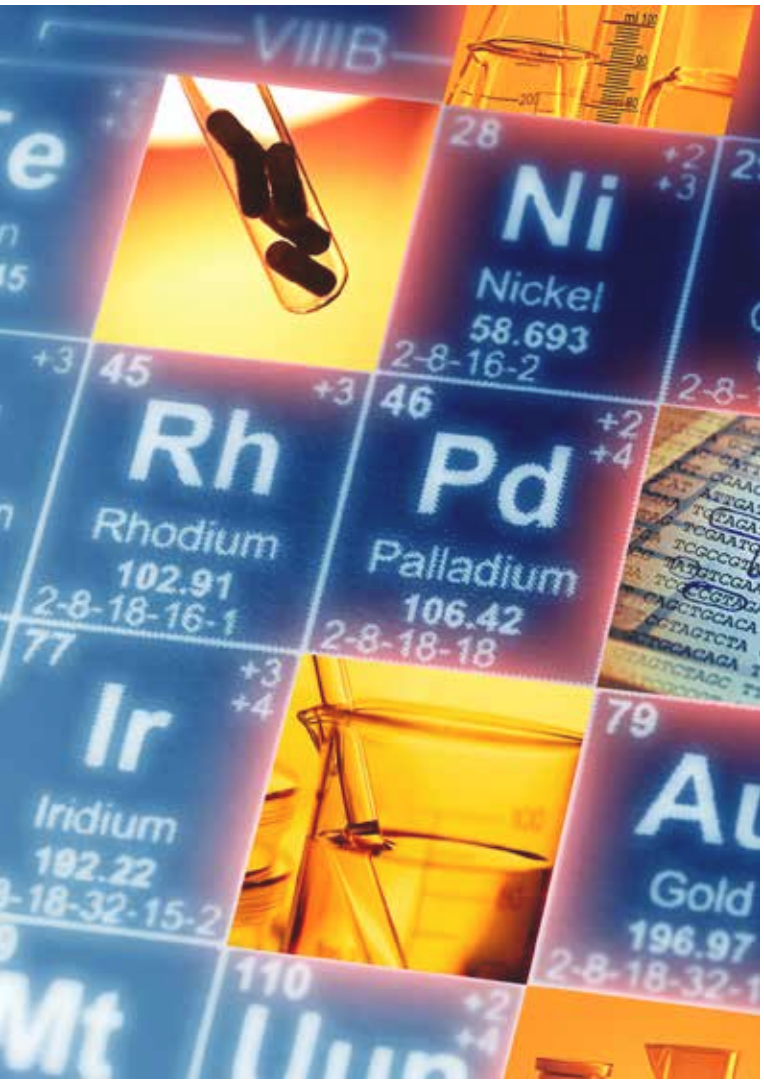
☐ Yes ☐ No

20. Do your symptoms get either worse or better at work?

☐ Yes ☐ No

At home:

☐ Yes ☐ No



Some Diseases Have Clinical Presentations That Are Similar To Common Medical Conditions And Display Nonspecific Symptoms And Physical Signs.

Knowledge of a patient's exposure to occupational and environmental factors is important for diagnostic, therapeutic, rehabilitative and public health purposes.

ENVIRONMENTAL HISTORY 06

1. Do you live next to or near an industrial plant, commercial business, dump site, or nonresidential property?

- [ ] Yes
- [ ] No

2. Which of the following do you have in your home?

- [ ] Air conditioner
- [ ] Air purifier
- [ ] Central heating
- [ ] Gas stove
- [ ] Electric stove
- [ ] Humidifier
- [ ] Wood

1

3. Have you recently acquired new furniture or carpet, refinished furniture, or remodeled your home?

- [ ] Yes
- [ ] No

4. Have you weatherized your home recently?

- [ ] Yes
- [ ] No

5. Are pesticides or herbicides (bug or weed killers; flea and tick sprays, collars, powders, or shampoos) used in your home or garden, or on pets?

- [ ] Yes
- [ ] No

6. Do you (or any household member) have a hobby or craft?

- [ ] Yes
- [ ] No

7. Do you work on your car?

- [ ] Yes
- [ ] No

8. Have you ever changed your residence because of a health problem?

☐ Yes ☐ No

9. Does your drinking water come from a private well, city water supply, or grocery store?

☐ Yes ☐ No

10. Approximately what year was your home built?

Approximate year:

If you answered "Yes" to any of the above, please answer below

Please answer below with the "Question Reference Number":

OTHER HEALTH HISTORY 07

PreventivePLUS Health Management

Family History

Indicate any blood relatives who have or had any of the following. Please mark the box to the right of the disease, indicate on the line their relation to you:

Condition	Mother	Father	Grandparent	Sister/Brother	Children
Anemia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Allergy	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	☐
Congenital Malformations	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Gallbladder Disease	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐
Sickle Cell Disease	☐	☐	☐	☐	☐
Stomach Ulcers	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐

If either of your parents are not living, list their age and cause of death, if known:

Mother died at age	Of
Father died at age	Of

Please check all that apply:

1. General Health

- [ ] Recent Weight Changes
- [ ] Weakness
- [ ] Fatigue
- [ ] Fever

2. Head

- [ ] Headache
- [ ] Head Injury
- [ ] Dizziness
- [ ] Lightheadedness

3. Skin

- [ ] Rashes
- [ ] Lumps
- [ ] Sores
- [ ] Itching
- [ ] Dryness
- [ ] Color Changes
- [ ] Changes in hair or nails
- [ ] Change in size/color moles

4. Neck

- [ ] Swollen Glands
- [ ] Goiter
- [ ] Pain
- [ ] Neck Stiffness

5. Eyes

- [ ] Vision changes
- [ ] Wears glasses or contacts
- [ ] Pain
- [ ] Excessive tearing
- [ ] Double or blurred vision
- [ ] Flashing lights
- [ ] Glaucoma
- [ ] Cataracts
- [ ] Dryness

6. Ears

- [ ] Ringing in the ears/tinnitus
- [ ] Spinning sensation
- [ ] Infections
- [ ] Earache
- [ ] Discharge
- [ ] Decreased hearing
- [ ] Wear hearing aid(s)

7. Nose/Sinuses

- [ ] Frequent colds
- [ ] Nasal congestion
- [ ] Discharge
- [ ] Itching
- [ ] Hay fever
- [ ] Nosebleeds
- [ ] Sinus trouble

8. Mouth/Throat

- [ ] Gums/teeth in poor condition
- [ ] Bleeding gums
- [ ] Dentures
- [ ] Tongue sores
- [ ] Frequent sore throats
- [ ] Hoarseness
- [ ] Dry mouth

9. Respiratory

- [ ] Shortness of breath
- [ ] Frequent Cough
- [ ] Asthma
- [ ] Wheezing
- [ ] Bronchitis
- [ ] Emphysema
- [ ] Blood in sputum
- [ ] History of pneumonia/TB

10. Cardiac

- [ ] Chest pain/discomfort
- [ ] Heart Murmur(s)
- [ ] Heart Trouble
- [ ] High Blood Pressure
- [ ] Heart palpitations/heart rate
- [ ] Sleeps on 2 pillows or more
- [ ] Swelling in legs
- [ ] Rheumatic Fever

11. Vascular/Hematologic

- [ ] Pain in the legs at night
- [ ] Leg cramps while awake
- [ ] Varicose veins
- [ ] Blood Clot in legs (DVT)
- [ ] Color changes in fingers or toes
- [ ] Easy Bruising or bleeding
- [ ] Past transfusions

12. Endocrine

- [ ] Heat or cold intolerance
- [ ] Thyroid Problems
- [ ] Excessive Sweating
- [ ] Excessive Thirst/Hunger
- [ ] Change in glove/shoe size

13. Musculoskeletal

- [ ] Arthritis
- [ ] Gout
- [ ] Backache
- [ ] Tongue sores
- [ ] Frequent sore throats
- [ ] Hoarseness
- [ ] History of trauma
- [ ] Swelling/redness/ pain/tender-ness at any muscle or joint
- [ ] Limitation of range of motion/ stiffness or activity

14.Neurologic

- [ ] Changes in speech
- [ ] Fainting
- [ ] Blackouts
- [ ] Seizures
- [ ] Changes in orientation/memory/ insight/judgment
- [ ] Paralysis
- [ ] Uncontrolled shaking of the hands
- [ ] Numbness/tingling or loss in sensation

15. Behavioral

- [ ] Mood changes
- [ ] Depression
- [ ] Memory problems
- [ ] Suicide Attempts
- [ ] Nervousness
- [ ] Tension
- [ ] Anxiety

16. Gastrointestinal

- [ ] Trouble swallowing
- [ ] Frequent heartburn
- [ ] Decreased appetite
- [ ] Nausea
- [ ] Jaundice
- [ ] Abnormal stool color
- [ ] Change in bowel habits
- [ ] Nausea
- [ ] Pain with passing stool
- [ ] Rectal Bleeding
- [ ] Black and tarry stools
- [ ] Hemorrhoids
- [ ] Constipation
- [ ] Diarrhea
- [ ] Abdominal Pain
- [ ] Excessive belching
- [ ] Hepatitis
- [ ] Irregular bowel movements
- [ ] Excessive passage of gas

17. Urinary

- [ ] Frequent Urination
- [ ] Blood in urine
- [ ] Burning on urination
- [ ] Urinary incontinence
- [ ] Kidney stones
- [ ] Reduced force of urinary stream/ hesitancy/dribbling
- [ ] Waking up at night to urinate
- [ ] Need to urinate frequently/urgently

18. Female Health

- [ ] Irregular menstrual cycle
- [ ] Premenstrual tension
- [ ] Pain during menstruation
- [ ] Vaginal Discharge
- [ ] Vaginal itching
- [ ] Vaginal lumps
- [ ] Exposure to DES

19. Male Health

- [ ] Hernia
- [ ] Penile sores
- [ ] Testicular pain
- [ ] Testicular Masses
- [ ] Scrotal pain/masses
- [ ] Erectile Dysfunction

20. Both Female/Male

- [ ] Chest pain/discomfort
- [ ] Heart Murmur(s)
- [ ] Heart Trouble
- [ ] High Blood Pressure
- [ ] Heart palpitations/heart rate
- [ ] Sleeps on 2 pillows or more
- [ ] Swelling in legs
- [ ] Rheumatic Fever

If you answered yes to any of the substances, please explain: List substance.

Answer:

Immunization, Vaccines, Antitoxins Record

Please provide / list information relating to Immunizations, Vaccines & or Antitoxins you may have had previously.

Vaccine	Trade Name	Date Given	Date Given	Date Given	Date Given
BCG					
Diphtheria					
Cholera					
Hepatitis A					
Hepatitis B					
Human papillomavirus					
Influenza					
Measles (Hard measles, 9-day measles)					
Measles, Mumps, Rubella (MMR)					
Meningo-coccal (e.g., MCV4, conjugate; MPSV4, polysaccharide) Give MCV4 IM.6Give MPSV4 SC.					
Pneumococcal					
Polysaccharide (PPSV23)					
Poliomyelitis					
Rabies					
RhoGAM					
Rubella					
Tetanus					
Typhoid					
Varicella					
Yellow fever					
Zoster					

Screening

When was the last time you had these preventive services?

Procedure	Less than 1yr	2-3 yrs ago	3-4 yrs ago	More than 5 yrs ago	Never	Don't Know
Colon Cancer Screen	☐	☐	☐	☐	☐	☐
Flu Shot	☐	☐	☐	☐	☐	☐
Blood Pressure	☐	☐	☐	☐	☐	☐
Cholesterol	☐	☐	☐	☐	☐	☐
Dental Exam	☐	☐	☐	☐	☐	☐
For Women Only						
Pap Test	☐	☐	☐	☐	☐	☐
Mammogram	☐	☐	☐	☐	☐	☐
Breast Exam by physician or RN	☐	☐	☐	☐	☐	☐
For Men Only						
Prostate Exam	☐	☐	☐	☐	☐	☐

Objectives Are The Basis For Monitoring Implementation Of Your Strategies And Progress Toward Achieving Your Program Goals.

Objectives also help set targets for accountability and are a source for program evaluation questions.

SMART Objectives
1. Specific
2. Measureable
3. Achievable
4. Realistic
5. Time-phased

YOUR HEALTH OBJECTIVES 08

Health Objectives

In the next six months, are you planning to make any changes to keep yourself healthy or improve your health? Please check each category or add one or two you would like to see changes.

	Yes	No	Don't Know	Not Needed
Increased physical activity	☐	☐	☐	☐
Lose Weight	☐	☐	☐	☐
Reduce alcohol use	☐	☐	☐	☐
Quit or cut down on smoking	☐	☐	☐	☐
Reduce Cholesterol/Fat intake	☐	☐	☐	☐
Lower blood pressure	☐	☐	☐	☐
Cope more effectively with stress	☐	☐	☐	☐
Add issues here:				
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Read Carefully & Sign:

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.

Signed:

Date:

Witnessed:

Date:

EXAMINATION QUESTIONNAIRE DONE.