

REFUAH HEALTH CENTER - PATIENT HEALTH ASSESSMENT

LAST NAME _____ FIRST NAME _____ MR# _____ DATE _____

MARITAL STATUS Single ___ Married ___ Widowed ___

NUMBER OF CHILDREN Boys _____ Girls _____

OCCUPATION _____

Medications taken on a daily basis	Dosage	Name	Dosage
1		6	
2		7	
3		8	
4		9	
5		10	

Vitamins/Herbal or other supplements taken on a daily basis
1
2
3
4
5

Allergies - Medications/IV contrast/Foods/
1
2
3
4
5

ILLNESSES/SYMPTOMS - in the column labeled "details" we ask that you provide: specific diagnosis and treatment or a description of the nature of the problem (how often does it occur, are there medications that make it better or worse etc.)

	Y	N	details		Y	N	details
Headaches				Bone/joint pain			
Ear/Hearing Problems				Circulatory Problems			
Eye/Vision Problems				Varicose Veins			
Thyroid Problems				Peripheral vacular disease			
Asthma				Blood in urine			
Cough				Pain/difficulty urinating			
Tuberculosis				Skin Problems			
High blood pressure				Weight gain > 10 lbs.			
Heart attack				Weight loss > 10 lbs.			
Chest pain				Cancer			
Abdominal pain				Diabetes			
Heartburn/Ulcer				Elevated cholesterol/lipids			
Constipation				Rheumatic Fever			
Blood in stool				Gout			
Diarrhea				Stroke			
Inflammatory bowel dis.							

REFUAH HEALTH CENTER - PATIENT HEALTH ASSESSMENT

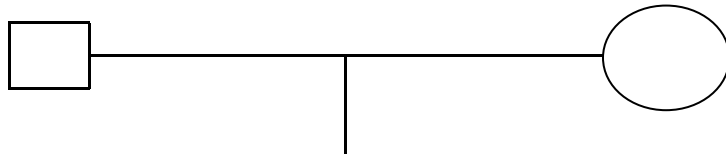
Previous Hospitalizations - Reason	When	Where

Previous Surgery - Reason	When	Where

is there a family history of:	Y	N	details	is there a family history of:	Y	N	details
Cancer				Hypertension			
Diabetes				Other			
Elevated cholesterol/lipids							

Do you smoke? Yes ___ No ___ how many packs/day ____ Alcohol use: never ___ rarely ___ every day ___
 Last blood test _____ last stool occult blood _____ last EKG _____ Last chest Xray _____
 Last tetanus shot _____ last pneumococcal vaccine _____ last flu shot _____
 Do you wear glasses Yes ___ No ___ last eye exam _____
 Last colonoscopy _____ last bone density test _____
 For women only:
 Last mammogram _____ Last menstrual period _____ last PAP smear _____

Family Tree
 include current age/age at death and significant medical history



MD Reviewer: _____
 Signature

REFUAH HEALTH CENTER - PATIENT HEALTH ASSESSMENT

ANNUAL UPDATE

LAST NAME _____ FIRST NAME _____ MR# _____ DATE _____

The following information will help ensure that your file is up-to-date

Medications taken on a daily basis	Dosage	Name	Dosage
1		6	
2		7	
3		8	
4		9	
5		10	

Vitamins/Herbal or other supplements taken on a daily basis
1
2
3
4
5

Newly Diagnosed Allergies - Medications/IV contrast/Foods/
1
2
3
4
5

ILLNESSES/SYMPTOMS - in the column labeled "details" we ask that you provide: specific diagnosis and treatment or a description of the nature of the problem (how often does it occur, are there medications that make it better or worse etc.)

	Y	N	details		Y	N	details
Headaches				Bone/joint pain			
Ear/Hearing Problems				Circulatory Problems			
Eye/Vision Problems				Varicose Veins			
Thyroid Problems				Peripheral vacular disease			
Asthma				Blood in urine			
Cough				Pain/difficulty urinating			
Tuberculosis				Skin Problems			
High blood pressure				Weight gain > 10 lbs.			
Heart attack				Weight loss > 10 lbs.			
Chest pain				Cancer			
Abdominal pain				Diabetes			
Heartburn/Ulcer				Elevated cholesterol/lipids			
Constipation				Rheumatic Fever			
Blood in stool				Gout			
Diarrhea				Stroke			
Inflammatory bowel dis.							

MD Reviewer:

Signature