

PATIENT SELF-ASSESSMENT FORM FOR INITIAL PRIMARY CARE OUT-PATIENT VISIT

We ask that all of our patients fill out this form at the time of their first visit. Please do your best to answer all the questions. If you do not understand a question, our staff can explain it. Everything is **CONFIDENTIAL** and part of your medical record.

Name:			Date of Birth:			Visit Date:			
Reason for Visit/ CC:									
History of Present Illness:									
<ul style="list-style-type: none"> • Any pain? <input type="checkbox"/> no <input type="checkbox"/> yes If yes, how severe? <input type="checkbox"/> mild (1 – 3) <input type="checkbox"/> moderate (4 – 6) <input type="checkbox"/> severe (7 – 10) • Where is the pain? 									
Review of Systems: Have you had ...				Review of Systems: Have you had ...					
• CONSTITUTIONAL			YES	NO	• EYES			YES	NO
Any recent weight change			<input type="checkbox"/>	<input type="checkbox"/>	Vision change in past 6 months			<input type="checkbox"/>	<input type="checkbox"/>
Fatigue > 6 months			<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses/ contact lenses			<input type="checkbox"/>	<input type="checkbox"/>
• RESPIRATORY					• EARS/ NOSE/ THROAT				
Chronic/ frequent cough			<input type="checkbox"/>	<input type="checkbox"/>	Change in hearing in past 6 months			<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath			<input type="checkbox"/>	<input type="checkbox"/>	Voice change			<input type="checkbox"/>	<input type="checkbox"/>
• CARDIOVASCULAR					Frequent nose bleeds			<input type="checkbox"/>	<input type="checkbox"/>
Chest pain			<input type="checkbox"/>	<input type="checkbox"/>	• GASTROINTESTINAL				
Palpitation/ irregular heart beat			<input type="checkbox"/>	<input type="checkbox"/>	Nausea/ vomiting			<input type="checkbox"/>	<input type="checkbox"/>
Cannot climb 2 flights of stairs			<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits			<input type="checkbox"/>	<input type="checkbox"/>
• MUSCULOSKELETAL					• GENITOURINARY				
Painful/ swollen joints			<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine			<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in walking			<input type="checkbox"/>	<input type="checkbox"/>	Difficulty holding urine			<input type="checkbox"/>	<input type="checkbox"/>
• NEUROLOGICAL					• PSYCHIATRIC				
Chronic/ frequent headaches			<input type="checkbox"/>	<input type="checkbox"/>	Feeling depressed/ sad lately			<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/ seizures			<input type="checkbox"/>	<input type="checkbox"/>	Nervous/ anxious			<input type="checkbox"/>	<input type="checkbox"/>
Memory problems			<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt			<input type="checkbox"/>	<input type="checkbox"/>
• ENDOCRINE					• SKIN				
Any loss in height			<input type="checkbox"/>	<input type="checkbox"/>	Hair loss/ excess hair growth			<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst/ urination			<input type="checkbox"/>	<input type="checkbox"/>	Rashes/ itching			<input type="checkbox"/>	<input type="checkbox"/>
• FOR WOMEN ONLY					• FOR MEN ONLY				
Abnormal vaginal discharge/ bleeding			<input type="checkbox"/>	<input type="checkbox"/>	Discharge from penis			<input type="checkbox"/>	<input type="checkbox"/>
Discharge/ lump in breast			<input type="checkbox"/>	<input type="checkbox"/>	Lump on testicles			<input type="checkbox"/>	<input type="checkbox"/>

