

# Comprehensive Health Assessment

<b>21 to 39 Years: Female</b>	Actual Age:	Date:
Medical Record #		
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
Name of Interpreter		
<b>Intake</b>	<b>Vital Signs</b>	
Allergies	Temp	
Height	BP	
Weight	Pulse	
BMI Value	Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date:	
<a href="#">Advance Directive</a> Info Given/Discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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)		
Limitations (physical or mental):		
<b>Interval History</b>		
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)	
Weight <input type="checkbox"/> Loss <input type="checkbox"/> Gain	_____ lbs <input type="checkbox"/> Intentional <input type="checkbox"/> Unintentional	
LMP:	G P A	<input type="checkbox"/> Menorrhagia
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:	
Last PAP	Date:	<input type="checkbox"/> WNL
<b>Current Alcohol / Substance Use</b>	<input type="checkbox"/> None <input type="checkbox"/> Alcohol	
<input type="checkbox"/> Drugs (specify):	<input type="checkbox"/> IV Drugs (or past Hx)	<input type="checkbox"/> Tobacco / Vape Packs/day:
<b>Family History</b>	<input type="checkbox"/> None <input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> HTN	<input type="checkbox"/> Hip fracture
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other:

Name:

DOB:

<b>Immunization History / Date</b>	<input type="checkbox"/> None <input type="checkbox"/> See <a href="#">CAIR</a>	<input type="checkbox"/> Tdap:	
<input type="checkbox"/> COVID #1: <input type="checkbox"/> COVID #2:	<input type="checkbox"/> Influenza:	<input type="checkbox"/> Varicella:	
<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> MMR:	<input type="checkbox"/> Zoster:	
<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> Pneumococcal:	<input type="checkbox"/> Other:	
<b>USPSTF Risk Screener</b>	<b>Screening Tools Used</b>	<b>Low Risk</b>	
		<b>High Risk</b> (see Plan/Orders/AG)	
Alcohol Misuse	<input type="checkbox"/> <a href="#">SHA</a> , <input type="checkbox"/> <a href="#">CRAFFT</a> , <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"/>
Depression	<input type="checkbox"/> <a href="#">PHQ2</a> , <input type="checkbox"/> <a href="#">PHQ9</a> , <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	<input type="checkbox"/> <a href="#">SHA</a> , <input type="checkbox"/> <a href="#">CRAFFT</a> , <input type="checkbox"/> H&P, <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"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/> <a href="#">SHA</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> <a href="#">HARK</a> , <input type="checkbox"/> <a href="#">HITS</a> , <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"/>
Sexually Transmitted Infections	<input type="checkbox"/> <a href="#">SHA</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/> <a href="#">SHA</a> , <input type="checkbox"/> <a href="#">CRAFFT</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> <a href="#">TB Risk Assessment</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Physical Examination</b>		<b>WNL</b>	
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	No lesions	<input type="checkbox"/>	
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 / Pharynx	Oral mucosa pink, no 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"/>	

# Comprehensive Health Assessment

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"/> Varicella (if not up to date)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> Hct / Hgb <input type="checkbox"/> Lipid panel
<input type="checkbox"/> HPV vaccine (if not up to date)	<input type="checkbox"/> Hep C Antibody test	<input type="checkbox"/> Low to moderate dose statin
<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"/> Meningococcal vaccine (if not up to date)	<input type="checkbox"/> HIV <input type="checkbox"/> Herpes	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomonas	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Pneumococcal (if high risk)	<input type="checkbox"/> Rx for folic acid 0.4-0.8mg daily	<input type="checkbox"/> Fasting plasma glucose / HbA1C
<input type="checkbox"/> Tdap	<input type="checkbox"/> PAP	<input type="checkbox"/> Bone Density Test
<input type="checkbox"/> Other:		

Name:

DOB:

## 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"/> Routine dental care	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Personal development
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Violent behavior	<input type="checkbox"/> Goals in life
<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Mindful of daily movements	<input type="checkbox"/> Family support, social interaction & communication
<input type="checkbox"/> Diabetes management	<input type="checkbox"/> Motor vehicle safety (DUI / no texting & driving)	<input type="checkbox"/> Academic or work plans
<input type="checkbox"/> Safe sex practices (condoms, contraception, HIV/AIDS)	<input type="checkbox"/> Seat belt	<input type="checkbox"/> Self-breast exam
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Breastfeeding
<input type="checkbox"/> Smoking/vaping use/exposure	<input type="checkbox"/> ASA use	<input type="checkbox"/> Sex education (partner selection)

## Tobacco Cessation

<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discuss smoking cessation medication	<input type="checkbox"/> Discuss smoking cessation strategies
--	---	---

## Next Appointment

<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:
---------------------------------	----------------------------------	---------------------------------

## Documentation Reminders

<input type="checkbox"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed 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)
