**********PATIENT ONLY**********

PATIENT ASSESSMENT FORM

(*this form to be completed and signed by the patient*)

To ensure your safety and to meet government requirements, the following **information is required each time you have a procedure performed.** Please take a moment to complete this form.

Name: Last: _____ First: _____MI _____
Date of Birth: _____ M/F:_____

1. What problem/symptom(s) are you having?_____
   Have you had a recent injury or trauma? No ☐ Yes ☐
   If yes, please describe:_____
   Are you currently in pain? No ☐ Yes ☐
   Is this exam specific to one side? Rt. ☐ Lt. ☐ No ☐
2. (Females age:10-55) Is there a possibility of pregnancy? No ☐ Yes ☐
   Date of last menstrual period ____/____/_____ Post-Menopausal? No ☐ Yes ☐
   Do you currently breast feed? No ☐ Yes ☐
3. Do you have an allergy to Latex? No ☐ Yes ☐
4. Are you in a relationship with someone who threatens you or physically hurts you? No ☐ Yes ☐ (P) ☐*
5. Do you have a history of falls or difficulty walking? No ☐ Yes ☐ (S) ☐*
6. Have you ever had, or been exposed to tuberculosis (TB)? No ☐ Yes ☐ *
7. Do you have a history of asthma? No ☐ Yes ☐ *
8. Have you had a pneumonia vaccine in the last year? No ☐ Yes ☐
9. Have you had a flu vaccine in the past year? No ☐ Yes ☐
10. Previous illnesses:
    Cancer: No ☐ Yes ☐ If yes, type _____Year Dx _____Treatment: Radiation ☐ Chemo ☐
    Diabetic: No ☐ Yes ☐ List diabetic medications:_____
    Hepatitis A,B,C: _____(year) Contagious/Communicable diseases_____

11. Previous surgery: No ☐ Yes ☐ If yes, circle all that apply:

Hernia	Lung_____	Pancreas	Splenectomy	Breast Bx or mastectomy
Appendectomy	Colon	Prostate	Sinuses	Ear_____
Back/Spine_____	Gallbladder	Thyroid	Tonsillectomy	Brain
Bone/Joint_____	Liver	Hysterectomy	Abdominal_____	Larynx

Kidney_____ List any Other surgeries:_____

12. List Allergies (food or medication): Iodine or "x-ray dye" Other: _____

13. List (or present a list) **All** Current medications (including over the counter medications):

_____

_____

14. Do you currently smoke? No ☐ Yes ☐ *
    If yes, for how many years_____ How much (per day) _____pack(s) _____other
    If no, have you ever smoked? No ☐ Yes ☐ Quit for how long? _____years/mths

Patient or Guardian signature_____ Date:_____

**P (Pamphlet to patient) *S (Sticker on armband) *Check for necessity*