

PATIENT SELF-ASSESSMENT FORM For INITIAL 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:			Site: <input type="checkbox"/> 1090 <input type="checkbox"/> Brodsky <input type="checkbox"/> PCIM-SL <input type="checkbox"/> PCIM-RH		
Date of Birth:			Date of Visit:		
Chief Complaint: <input type="checkbox"/> Initial Preventive Visit (<i>Physical</i>) <input type="checkbox"/> Specify:					
History of Present Illness:					
• <i>Main symptom:</i>					
• <i>Where is the problem/ pain?</i>					
• <i>How severe is the problem/ pain?</i> <input type="checkbox"/> none <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> worst					
• <i>How long have you had this problem/ pain?</i> <input type="checkbox"/> hours <input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years					
• <i>Other associated symptoms/ problems:</i>					
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 mos.	<input type="checkbox"/>	<input type="checkbox"/>
Persistent fever	<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses/ contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue > 6 months	<input type="checkbox"/>	<input type="checkbox"/>	• EARS/ NOSE/ THROAT		
• RESPIRATORY			Change in hearing in 6 mos.	<input type="checkbox"/>	<input type="checkbox"/>
Chronic/ frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Voice change	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
• CARDIOVASCULAR			• GASTROINTESTINAL		
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation/ irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Cannot climb 2 flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/ vomiting	<input type="checkbox"/>	<input type="checkbox"/>
• MUSCULOSKELETAL			Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>
Painful/ swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	• GENITOURINARY		
Difficulty in walking	<input type="checkbox"/>	<input type="checkbox"/>	Burning/ pain on urination	<input type="checkbox"/>	<input type="checkbox"/>
• HEMATOLOGIC/ LYMPH.			Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Easy bleeding/ bruising	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty holding urine	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in neck, armpits, groin	<input type="checkbox"/>	<input type="checkbox"/>	Sexual difficulty	<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"/>
Any fall in past 12 months	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/ anxious	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/ seizures	<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems	<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"/>
Bothered by hot/ cold weather	<input type="checkbox"/>	<input type="checkbox"/>	Change in skin color	<input type="checkbox"/>	<input type="checkbox"/>
• FOR WOMEN ONLY			• FOR MEN ONLY		
Abnormal vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Discharge from penis	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge/ lesions	<input type="checkbox"/>	<input type="checkbox"/>	Sore/ lump on 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"/>
Name & Age:			Date of Visit:		DOB:

