Operation PAR, Inc.
OUTPATIENT HEALTH SCREENING

Client First Name | M.I. | Program/RU# | Client ID#

Last Name | Today's Date

Place of Service:_____ Start Time:_____ End Time:_____

Date of Birth: _____

General Medical

1. Are you in need of any medical attention at this time? ❒ Yes ❒ No
   (If yes, explain:_____)
2. Do you have any allergies (drug, insects, food, etc.) ? ❒ Yes ❒ No
   (If yes, what?_____)
3. Do you suspect that you have or are you being treated for any contagious or sexually transmitted diseases? ❒ Yes ❒ No
   (If yes, what?_____)
4. Are you experiencing pain anywhere in your body (including teeth)? ❒ Yes ❒ No
   (If yes, explain:_____)
5. Have you taken non-prescription drugs or alcohol to lessen the pain? ❒ Yes ❒ No
   (If yes, explain:_____)
6. Within the past 3 months, have you fallen or been injured including accidents, fights, head injuries? (If yes, explain:_____) ❒ Yes ❒ No
7. Are you under the care of any physician or clinic? ❒ Yes ❒ No
   (If yes, name of physician or clinic:_____)
8. In the past, have you been told you are in need of surgery? ❒ Yes ❒ No
   (If yes, when, by whom & what kind:_____)
9. In the past 6 months, have you taken any medications? (including Rx, Herbal Medications & Over-the-Counter Medications): ❒ Yes ❒ No
   If yes, indicate medication, dose, frequency, purpose and prescribing physician:

Medication	Dose	Duration	Purpose	Effective Yes/No	Prescribing Physician

10. Were any medications prescribed that you did not take? ❒ Yes ❒ No
    (If yes, indicate medications and reasons refused:_____)
11. Do you have any physical limitations? ❒ Yes ❒ No
    (If yes, explain and list any assistive technology needed) _____
    _____)

Confidential -- For Professional Use Only

Date ☐☐-☐☐-☐☐ Client ID# ☐☐☐☐☐☐☐☐

Outpatient Health Screening

12. Major Illnesses: ❒ Tuberculosis ❒ Hepatitis ❒ Hypertension ❒ Diabetes
❒ Cancer ❒ Ulcer ❒ HIV ❒ Heart Disease
❒ Other _____

Mental Illnesses: ❒ Depression ❒ Anxiety ❒ Bi-Polar ❒ Schizophrenia
❒ Other _____

13. Have you had a seizure or episodes of loss of consciousness? ❒ Yes ❒ No
(If yes, explain:_____)

14. Tuberculosis Screening: Check all that apply

☐ Cough - How Long? _____ ☐ Fever Date of last TB Test _____
Productive/Non-productive Results of last TB Test _____
☐ Coughing up blood ☐ Night Sweats
☐ Infections - Bronchitis/Pneumonia ☐ Weight Loss
Tuberculosis/ Other _____ ☐ Exposure to T.B.

Current Client Health Practices -- Past 6 months

1. **Weight:** ❒ Gain ❒ Loss **How much?** _____ ❒ No problem
Are you satisfied with your present weight? ❒ Yes ❒ No
2. Do you use periods of binging and purging to control your weight? ❒ Yes ❒ No
3. Do you use laxatives regularly? ❒ Yes ❒ No (If yes, how often and why?_____)
4. Do you use tobacco products? ❒ Yes ❒ No (If yes, how much?_____)

Females

1. Do you think you are currently pregnant? ❒ Yes ❒ No
2. Date of last menstrual cycle_____ Date of last pregnancy:_____
3. Did you experience any problems with last pregnancy? ❒ Yes ❒ No
4. Have you had your postpartum check up? ❒ Yes ❒ No

Children & Adolescents

Are immunizations current? ❒ Yes ❒ No (If no, refer to health care provider.)

_____ _____
Client Signature Date

❒ Client referred to County Health Department because last TB test over 1 year ago and/or client is showing signs/symptoms of active TB.

❒ Client and/or parent report no other health concerns that would interfere with treatment or require medical referral.

❒ Other Items which may require attention: Referrals to:

_____ _____
_____ _____

_____ _____
Clinician's / Counselor's Signature & Credentials Date