Rosary Hall Outpatient Assessment
CURRENT AND LIFETIME MEDICAL PROBLEMS

Name _____

Medical Record # _____

Date of Birth: _____

(Please check if you have EVER had any of the following medical problems or diagnoses)

___ 1 No Medical Problems or Diagnoses
___ 2 Fainting or Unconsciousness
___ 3 Frequent or Severe Headaches
___ 4 Convulsions, Fits, or Seizures
___ 5 Stroke or Paralysis
___ 6 Eye Disorder (other than glasses)
___ 7 Ear Trouble or Hearing Loss
___ 8 Asthma
___ 9 Pneumonia
___ 10 Chronic Bronchitis
___ 11 Emphysema
___ 12 Tuberculosis
___ 13 Positive TB Skin Test
___ 14 Chest Pain, Pressure, or Tightness
___ 15 Heart Disease or Heart Attack
___ 16 High Blood Pressure
___ 17 Stomach Trouble, Ulcer, or Gastritis
___ 18 Hepatitis, Jaundice, or Cirrhosis
___ 19 Rectal Bleeding (except hemorrhoids)
___ 20 Pancreatitis
___ 21 Diabetes
___ 22 Kidney Disease
___ 23 Painful or Frequent Urination
___ 24 Bloody or Discolored Urine
___ 25 Sexually Transmitted Diseases
___ 26 Cancer, Tumors, Cysts, or Growths
___ 27 Amputations or Dislocations
___ 28 HIV Positive (AIDS)
___ 29 Fracture or Deformity of Bones/Joints
___ 30 Thyroid Trouble or Goiter
___ 31 Bleeding Tendency
___ 32 Anemia or Low Blood Count
___ 33 Sickle Cell Disease
___ 34 Allergies
___ Other Problem Not Listed

(Description) _____

_____

ST. VINCENT CHARITY
MEDICAL CENTER
2351 EAST 22ND STREET
CLEVELAND, OH 44115
stvincentcharity.com
A Ministry of the Sisters of Charity Health System

PATIENT LABEL

For each item listed on the first page put the following:

Item # ____________ What was the specific problem ______________________________
When was it diagnosed? ____________________________ Is this a current problem? ☐ Yes ☐ No
Name of physician providing care ____
Date of your next appointment with the physician _________________________________
Name of the medical clinic or hospital ____
List medications you are taking for this condition. (include herbs and mixtures)

Name	Amount	Frequency

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List all surgeries and dates.

_____

_____

In general would you say your health is (circle one)

Very Good Good Fair Poor Very Poor

In the last year how many visits for your healthcare have you made to:

A Doctor's office or clinic _____
A hospital emergency room _____
Over night admits to a hospital _____
A dentist _____
Other outpatient treatment _____

Do you have any eating disorders? ..... **yes** / **no**
When you sleep do you sweat a lot or have chills? ..... **yes** / **no**
Have you been coughing continually for more than three weeks? ..... **yes** / **no**
Do you cough up blood? ..... **yes** / **no**
Have you engaged in sexual behavior that might have put you at risk for sexually transmitted disease or HIV/AIDS? ..... **yes** / **no**
Has someone else ever injected you with a needle to get high on drugs? ..... **yes** / **no**
Have you ever, even one time, shared a needle or "works" with another person? ..... **yes** / **no**

Women only.

When was your last menstrual period? _____ Was it normal? ..... **yes** / **no**
When was your last PAP Smear? _____ Was it normal? ..... **yes** / **no**
Have you had any unusual vaginal discharge in the last three months? ..... **yes** / **no**
Are you currently pregnant? **yes** / **no** If yes, what trimester are you in? **1st** **2nd** **3rd**

_____
Client signature

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PATIENT LABEL

Staff use only on this page.

Pain Screening:

Pain Scale 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10

No Pain Mild Discomforting Distressing Horrible Excruciating

Counselor comments regarding Pain (eg. Character, frequency, location, duration).

_____

_____

Nutritional Screening

yes no Client appears cachectic/malnourished.
yes no Client has non - healing wounds.
yes no Client has unintentionally lost 10 pounds within past 2 months
yes no Client is pregnant or lactating
yes no Client has had gastric bypass surgery
yes no Client is diagnosed with newly onset diabetes, hyperlipidemia or other disease condition that will benefit from nutrition intervention

An answer of "yes" to one or more of the above nutritional criteria would warrant a review by Medical Director and Counselor to circle **"YES"** below for Medical Director to review nutritional screening.
If all responses are "no" Counselor to circle "no" below.

Counselor comments. _____

_____

_____

_____

_____

Counselor signature _____ date _____

Nutritional criteria warrant a review by Medical Director. **YES** / **NO** **(Counselor circle one)**

Physician comments. _____

_____

_____

_____

_____

Recommendations

Client is medically cleared for outpatient treatment. YES / NO

_____

_____

_____

_____

Reviewed by (Physician signature) _____

Date and Time _____