

Comprehensive Health Assessment

40 to 49 Years: Male	Actual Age: _____	Date: _____
Medical Record #		
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
Name of Interpreter		
Intake		Vital Signs
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: _____	
Advance Directive 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		
Limitations (physical or mental): _____		
Interval History		
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	
Sexually active	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Multiple Partners <input type="checkbox"/> MSM	
Contraceptive Used	<input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____	
Last Colonoscopy	Date: _____	<input type="checkbox"/> WNL
Current Alcohol / Substance Use	<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: _____
Family History	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other: _____
Immunization History / Date	<input type="checkbox"/> None <input type="checkbox"/> See CAIR	<input type="checkbox"/> Tdap: _____
<input type="checkbox"/> COVID #1:	<input type="checkbox"/> Influenza:	<input type="checkbox"/> Varicella:
<input type="checkbox"/> COVID #2:	<input type="checkbox"/> MMR:	<input type="checkbox"/> Zoster:
<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> Pneumococcal:	<input type="checkbox"/> Other: _____

Name: _____

DOB: _____

USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Alcohol Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/> PHQ2 , <input type="checkbox"/> PHQ9 , <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"/> SHA , <input type="checkbox"/> CRAFFT , <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"/> SHA , <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"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination		WNL	
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	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"/>	
Male	Circ/uncircumcised, testes in scrotum Prostate Exam / Rectal	<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"/>	

Comprehensive Health Assessment

Subjective / Objective
Assessment
Plan
Referrals
Orders

Name:

DOB:

Anticipatory Guidance (AG) / Education (✓ if discussed)
Diet, Nutrition & Exercise
Accident Prevention & Guidance
Tobacco Cessation
Next Appointment

Documentation Reminders

MA / Nurse Signature, Title, Date
Provider Signature, Title, Date

Notes (include date, time, signature, and title on all entries)