CMHPSM Personal Health Record: Adult

To Be Filled Out/Completed by Adult Consumer.

Name: ____ DOB: ______________________________

CRCT #: __________________________

☐ I decline to complete the Personal Health Review

History

Person providing information: ☐Self ☐ Parent ☐Guardian ☐ Foster parent
☐ Other specify: ________________

Do you have a Primary Care Provider? ○ Yes ○ No ○ Decline
(E.g. Doctor, Physician Assistant, Nurse Practitioner)

Name________________________________

If *No*, would you like help finding a Primary Care Provider? ○ Yes ○ No ○ Decline

Have you seen your Primary Care Provider in the last year? ○ Yes ○ No ○ Decline

Have you had any recent surgeries or medical procedures? ○ Yes ○ No ○ Decline

If *Yes*, what/when: ____

Have you been hospitalized in the past year? ○ Yes ○ No ○ Decline

If *Yes*, please describe_______________________________

Have you gone to the emergency room in the last year? ○ Yes ○ No ○ Decline

How many times in the past year? ○1-2 ○ 3-4 ○ 5 or more times

If *Yes*, please describe: ____

Do you have a dentist? ○ Yes ○ No ○ Decline

Have you seen your dentist in the last year? ○ Yes ○ No ○ Decline

Name of Dentist - ____________________________________

Do you use specialized equipment or devices? ○ Yes ○ No ○ Decline

Examples include: wheelchair, walker, lift, CPAP, hearing aids, cochlear implants, glasses/contacts, oxygen

If *Yes*, please describe: ____

Is the equipment/device(s) in working order? ○ Yes ○ No

Do you need any assistance with the equipment/devices? ○ Yes ○ No

If *Yes*, please describe: ____

Are your immunizations up to date (flu, TDAP, Tetanus, Tuberculosis TB, HPV, Hep A)

○ Yes ○ No ○ Unknown

If *No*, why? ___________________________

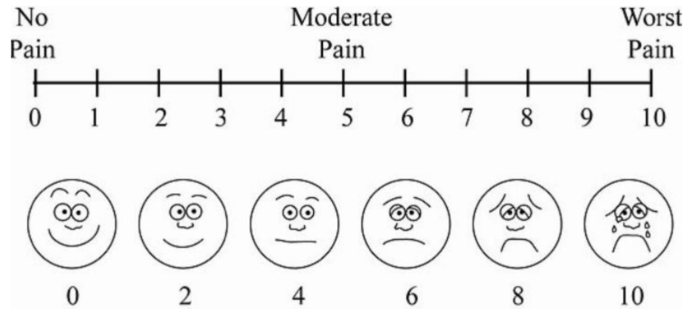
Have you been in contact with anyone with Tuberculosis (TB)?

○ Yes ○ No ○ Unknown

Pain

Do you experience pain that interferes with daily activities? ○ Yes ○ No

Please indicate your current level of pain:



Where is your pain? ____

Describe your pain: e.g.: dull, sharp, burning, pins & needles, tingling, throbbing, etc.

____

How often do you have pain?

____

What do you do to ease your pain? How do you treat your pain?

____

Health Conditions

Have you ever been told that *you have*:

High Blood Pressure ○ Yes ○ No ○ Decline

If *Yes*, please describe treatment___________________________________

Hepatitis ○ Yes ○ No ○ Decline

If *Yes*, please describe treatment: ___________________________________

High Cholesterol ○ Yes ○ No ○ Decline

If *Yes*, please describe treatment: ___________________________________

Heart Attack/Heart Disease ○ Yes ○ No ○ Decline

If *Yes*, please describe treatment: ____________________________________

Diabetes ○ Type 1 ○ Type 2 ○ Yes ○ No ○ Decline

If *Yes*, please describe treatment: ____________________________________

Asthma ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment: ______________________________________
COPD ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment: ____
Cancer ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment____
Tuberculosis (TB) ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment: ____
Seizure Disorder ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment: ____
Thyroid Issues ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment: ____
Other Medical Conditions not listed ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment: ____

Does you have SIBLINGS, PARENTS or GRANDPARENTS who have:

High Blood Pressure ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
Hepatitis ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
High Cholesterol ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
Heart Attack/Heart Disease ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
Diabetes: ○ Type 1 ○ Type 2 ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
Asthma ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
COPD ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
Cancer ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐Grandparents
Tuberculosis (TB) ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐Grandparents
Seizure Disorder ○ Yes ○ No ○ Unknown
☐ Siblings ☐Parents ☐ Grandparents
Thyroid Issues ○ Yes ○ No ○ Unknown

☐ Siblings ☐ Parents ☐ Grandparents

Other Medical Conditions not listed? ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
Please describe Other : ____

Wellness

In general, how would you rate your health?

○ Excellent ○ Good ○ Fair ○ Poor ○ Decline to answer
How could you improve your health? ____

Physical Activity

In the last **7 days**, how many times were you:

Physically Active for at least 20 minutes in a day
○ Everyday ○ 2-6 days ○ 1-2 days ○ 0 Days
What did you do for physical activity? ____

Eat 3 or more servings of fruits or vegetables in a day
○ Everyday ○ 2-6 days ○ 1-2 days ○ 0 Days

Tobacco Use

In the last **30 days:**
Have you smoked or used chew tobacco? ○ Yes ○ No
If yes, how many packs per day? ______
If yes, do you want to quit tobacco use? ○ Yes ○ No ○ Unknown ○ Decline to answer
Do you live with/ or around someone who smokes? ○ Yes ○ No

Diet

Do you have a special diet? ○ Yes ○ No
(E.g. diabetic, low salt, pureed, thickened liquids, laxatives, lactose free, gluten free, etc.)
If yes, what type of diet? ____
Do you ever intentionally vomit after eating? ○ Yes ○ No
How often? _______________
Have you ever taken laxatives or diet pills to help you lose weight? ○ Yes ○ No
Do you drink caffeinated beverages? *(E.g. soda, coffee, energy drinks, etc.)* ○ Yes ○ No
If yes, what type: ___________ How much? ___________________

Allergies/Adverse Reactions

Do you have allergies to the environment *(e.g. cats, dogs, dust mites, etc.)*? ○ Yes ○ No

If *Yes*, explain___________________________

What is the reaction? _____________________

Do you have any allergies to food(s)? ○ Yes ○ No

If *Yes*, explain___________________________

What is the reaction? _____________________

Do you have any allergies to medications? ○ Yes ○ No

If *Yes*, explain___________________________

What is the reaction? _____________________

Symptoms

Check all that apply for you

☐ **Frequent Headaches** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Confused or forgetful** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Head injury** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Mood changes** ○ New Issue ○ Ongoing
Are you receiving treatment? O Yes ○ No

☐ **Eye or vision problems** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Trouble hearing** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Teeth problems** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Changes in skin/moles** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Finger or toenail problems** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Rashes or sores that do not heal** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Easily bruised/Anemic** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Difficulty walking** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Falls** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Excessive thirst** ○ New Issue O Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Difficulty swallowing** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Frequent nausea vomiting** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Coughing up blood** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Decrease in Food Intake/Appetite** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Stomach pain/upset stomach** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Frequent urination** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Painful urination** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Diarrhea** ○ New Issue ○ Ongoing
Are you receiving treatment? ○Yes ○ No

☐ **Constipation** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Rectal bleeding** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Rapid/irregular heartbeat** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Chest pain/chest tightness** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐**Heart problems** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Shortness of breath** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Wheezing** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Frequent colds** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

☐ **Persistent cough lasting over 3 weeks** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No
☐ **Sleep problems** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No
☐ **Weight gain of over 10 pounds** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No
☐ **Weight loss of over 10 pounds** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No
☐ **Weak or tired all the time** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No
☐**Swollen ankles/feet** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No
☐ **Numbness or tingling** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No
☐ **Shaking or tremors** ○ New Issue ○ Ongoing
Are you receiving treatment? ○ Yes ○ No

Please describe any of the "Yes" responses from the Symptoms:

____

____

Prevention & Sexual Activity

If Male

When was the last time you:

Had a prostate exam?
○ 6 mo ○ 1 year ○ 1-2 years ○ Greater than 3 years ○ Never ○ Unsure

If Female:

When was the last time you:

Had a mammogram?:
○ 6 mo ○ 1 year ○ 1-2 years ○ Greater than 3 years ○ Never ○ Unsure
Had a pap smear?:
○ 6 mo ○ 1 year ○ 1-2 years ○ Greater than 3 years ○ Never ○ Unsure
Could you be pregnant? ○ Yes ○ No ○ Decline to answer
Date of Last Menstrual Period___________ ☐ Not Sure

When was the last time you:

Had a colonoscopy?

○ 6 mo ○ 1 year ○ 1-2 years ○ Greater than 3 years ○ Never ○ Unsure

Had your stool checked for blood?

○ 6 mo ○ 1 year ○ 1-2 years ○ Greater than 3 years ○ Never ○ Unsure

Were screened for HIV/AIDS?

○ 6 mo ○ 1 year ○ 1-2 years ○ Greater than 3 years ○ Never ○ Unsure

Are you currently sexually active? ○ Yes ○ No ○ Decline to answer

If you have ever been sexually active, do you practice safe sex? ○ Yes ○ No

Method of protection?

☐The Pill ☐Male Condom ☐Female Condom ☐Diaphragm ☐IUD ☐Cervical Cap ☐ Vaginal Ring ☐Sponge ☐Implant ☐Natural Family Planning ☐Morning After Pill ☐Female Sterilization ☐ None ☐Depo shot ☐ Decline to answer

Do you have concerns regarding Sexually Transmitted Diseases?

○ Yes ○ No ○ Decline to answer

If yes, explain________________________________

Medications

Please list all prescribed medications, over-the-counter medications, vitamins, herbals, homeopathic medications

Medication Name	Strength e.g. how many milligrams, if known	Directions for use	Start Date (approximate)	Prescriber (or put OTC- for over the counter Meds)

Are your medications helpful?

○ Yes ○ No ○ Sometimes ○ Decline

If *No*, explain________________________________

Do you take medications as prescribed? ○ Yes ○ No ○ Sometimes ○ Decline

Do you have any side effects?

○ Yes ○ No ○ Sometimes ○ Decline

If *Yes*, explain________________________________

Is your prescriber aware of any concerns related to your medication?

○ Yes ○ No ○ Sometimes ○ Decline

Have you taken other medications in the past to treat your conditions?

○ Yes ○ No ○ Sometimes ○ Decline

If *Yes*, explain________________________________

Have you had labs drawn in the last 12 months?

○ Yes ○ No ○ Unsure

Vitals

Estimated Height _____ Feet ____Inches Estimated Weight ______pounds

Readiness to Change

(Small everyday changes can have a big impact on your health. Think about changes you would be most interested in making over the next year. Look at the list below and choose one or more):

☐ Exercise regularly
☐ Eat Healthy
☐ Lose weight
☐ Gain weight
☐ Cut back/quit smoking or using tobacco
☐ Get an annual Flu shot
☐ Attend annual doctor and specialist appointments, following up as needed
☐ Cut back or quit drinking alcohol/substances
☐ Seek treatment for Substance Use
☐ Commit to keeping up all healthy things I do now
☐ Other:__________________________________
☐ Decline to respond