DAUPHIN COUNTY WORK RELEASE CENTER
HEALTH ASSESSMENT FORM

NOTE: This form must be completed only by a licensed medical provider and must be placed in a sealed envelope addressed "ATTENTION MEDICAL PROVIDER"

Date of Assessment: _____

Patient Name: _____

Date of Birth: _____ **SSN**: _____

Insurance Information

Name of Health Insurance Co. _____ Policy#: _____

Group No: _____ Are Referrals Needed for Care: Yes_____ No_____

MEDICAL HISTORY AND PHYSICAL EXAM

Review of System – Indicate problem in comment section:

Y	N	System	Comment	Y	N	System	Comment
		Headache				Anemia	
		Seizures				Bleeding	
		Blackouts				Bruising	
		DT's				Arthritis	
		Skin				Gout	
		Hearing				Back Pain	
		Ears				Kidney/bladder	
		Vertigo				Gonorrhea	
		Vision				Chlamydia	
		Speech				Syphilis	
		Dental				Herpes	
		Chewing Problem				Crabs/Lice	
		Swallowing				HIV/AIDS	
		Joint Problems				Prostate	
		Muscle				Hernia	
		Ulcers				**Breast**	
		Gallbladder				**Vaginal Discharge**	
		Hepatitis & Type				**Menarche Age**	
		Hemorrhoids				**LMP / Duration**	
		Thyroid				**Cycle / Flow**	
		Diabetes				**Pregnancies**	**G: P:**
		Allergies				**Miscarriages/Abortions**	
		Hay Fever				**Pregnancy Complications**	
		Asthma				**Mammogram Date:**	
		Pneumonia				**Contraceptive Use/Type**	
		Heart Disease				**UTI / Pelvic Infections**	
		Hypertension				**Pregnant Now?**	
		Edema Swelling				**Pregnant Test?**	**(+) (-)**

Any other known/chronic conditions not listed above:

_____

_____

Tuberculosis Testing *(Must Have Test Completed With-in Last 60 Days)*:

Previous Testing: Yes: _____ No: _____ Results: _____mm

Past Positives: Date: _____ Location: _____ (***Past Positives MUST be verified***)

Date PPD Planted	Nurses Initials	Date Read	Nurses Initials	Reaction 10mm or > = CXR	CXR Date	Results of CXR
				MM		

COVID-19 Testing *(Must Have Test Completed With-in Last 10 Days)*:

Date Tested: _____ Location: _____ Date Results Expected: _____

Immunizations with Date of Last Vaccine/Dose *(If Known)*:

COVID-19: _____ Flu: _____ Hepatitis B: _____ Rubella: _____

Pneumovax: _____ Tetanus: _____ (Other: _____ Date: _____)

Vital Signs at Time of Assessment:

Blood Pressure: _____ Temperature: _____ Pulse: _____

Respiration: _____ Height: _____ Weight: _____

Any Psychiatric, Mental Health and/or Intellectual Disabilities Concerns: Yes ☐ No ☐

If Yes, explain: _____

Physical: Mark "N" if normal and "A" if abnormal in the box in front of the appropriate area and explain abnormalities.

		(Comments)			(Comments)
	Alert, oriented, co-op			Upper Ext.	
	Head, Scalp, face			Pulses	
	Eyes (EOMI, PERRLA)			Spine	
	Eyes (Sclera, Trauma)			Lower Ext.	
	Ears			Feet	
	Nose Lips, Gums, Teeth			GU System	
	Neck (masses, supple)			Lymph	
	Thorax			Skin	
	Lungs			Gait Balanced	
	Heart			HEARING	AD: AS: AU:
	Abdomen (GI)			VISION	OD: OS: OU:

Currently on any medication: Yes ☐ No ☐ **If Yes**, name of medication & dosage: _____

_____

_____

Comments: _____

Any scheduled or recommended follow-up care or treatment: Yes ☐ No ☐

If Yes: Where: _____ Date: _____ Time: _____

Provider Name (*Printed*): _____ License #: _____

Signature: _____ Specialty: _____

Primary Care Physician: _____ Telephone: _____

Address: _____