COUNSELING at DUPONT

Health Assessment Self Report

Name _____ **Date** _____

Do you have any of the following chronic Health Problems?

- ❒ Y ❒ N Cancer
- ❒ Y ❒ N Tuberculosis
- ❒ Y ❒ N Hypertension
- ❒ Y ❒ N Pulmonary
- ❒ Y ❒ N Seizures
- ❒ Y ❒ N Heart Disease
- ❒ Y ❒ N Sexually Transmitted Diseases (STD)
- ❒ Y ❒ N Human Immunodeficiency Virus
- ❒ Y ❒ N CVA/Stroke
- ❒ Y ❒ N Dental Problems
- ❒ Y ❒ N Vision Problems
- ❒ Y ❒ N Arthritis
- ❒ Y ❒ N Incontinence
- ❒ Y ❒ N Headaches
- ❒ Y ❒ N Skin Disorder
- ❒ Y ❒ N Hearing Deficit
- ❒ Y ❒ N Gastrointestinal Disorders
- ❒ Y ❒ N Diabetes If yes, do you take Insulin? ❒ Y ❒ N

Other medical condition not listed above:

_____

_____

History of hospitalizations:

Condition/dates/Hospital/outcome

_____

_____

Surgeries: List and provide dates:

_____

_____

Pain Assessment:

Location of pain _____

Exacerbating factors _____

Intensity (mild, moderate, severe) _____

Time of day pain is more active _____

Consequence of pain (emotions, mobility, social interactions, etc.) _____

_____

Any additional medical information not captured above?

_____

_____

List current medications to include doses, purpose and regimen:

_____

_____

_____

_____

_____

Known Allergies

_____

_____

_____

_____

_____ _____

Signature **Date**