Attachment A: Capital Area Human Service District
Adult Physical Health Questionnaire

Name: _____ Date: _____
Date of Birth: _____ Race: _____ Sex: _____

	Yes	No	Comments
1. Do you have a personal history of: Diabetes Hypertension Cardiovascular Disease			
2. Do you have a family history of: Diabetes Hypertension Cardiovascular Disease If yes, whom?			
3. Do you have a medical doctor (PCP)? If yes whom?			Name:
4. Have you seen your medical doctor in the last year?			Last Visit:
5. Have you had a hospital or ER visit in the last year?			Reason:
6. Do you have a dentist?			Name:
7. Have you seen your dentist in the last year?			Last Visit:
8. Do you use over the counter medications (vitamins, herbs, cold medication, etc.)?			
9. Are you allergic to any foods, medications, or latex?			
10. Are your immunizations up to date?			What: When:
11. Have you ever had a pneumonia shot? (Ages 65 and older)			
12. Have you had a positive TB skin test or chest x-ray to rule out active TB?			
13. Do you want a TB skin test?			Document pre- and post-test counseling.
14. Do you have a family history of tobacco use or does someone in your home smoke?			
15. Do you smoke or chew tobacco?			
16. If yes, are you interested in quitting?			
17. Are you interested in nicotine replacement therapy?			
18. Are you physically active?			
19. Are you sexually active?			
20. Do you practice sex with protection?			
21. What method of contraception do you use?			
22. Date of last menstrual period: _____ Are you pregnant or trying to become pregnant? Are you interested in getting tested for pregnancy?			

23. Have you ever had an HIV test?			
24. Are you interested in having an HIV test?			Document referral and follow up.
25. Have you had a prostate exam?			Date:
26. Have you ever been screened for Colorectal Cancer? (Ages 50 – 75)			
27. Have you had a mammogram?			Date:
28. Have you had a pap smear?			Date:
29. Do you regularly experience bodily pain? Please indicate level of pain by circling the correct number.			

30. Please (✓) check any of the following that apply to you:

		Comment			Comment
	Frequent headaches			Stomach pain/ upset	
	Dizzy/ frequent falling			Recent weight gain/ loss	
	Seizures			Constipation	
	Confused/ forgetful			Rectal bleeding/ bloody stools	
	Increased thirst/ increased urination			Painful/ difficulty urinating	
	Eye/vision problems			Bedwetting	
	Poor hearing			Sleep problems	
	Frequent cold/ coughing			Muscle stiffness/ muscle pain	
	Wheezing/ shortness of breath			Irregular heartbeat/ chest pain	
	pneumonia			Bruise easily/ anemia	
	Weak/ tired all the time			Mouth/ teeth problems	
	Shaking/ trembling				

Client/Guardian Signature: _____ Date: _____

Client Representative Signature: _____ Date: _____
(If applicable)

For CAHSD Staff Use Only

- ☐ Physical health screening information reviewed with client
- ☐ Client educated on primary care/preventive resources
- ☐ Physical health problem identified _____
- ☐ Physical health goal stated by the client _____
- ☐ Recommended to continue care with current primary care provider Provider's name: _____
- ☐ Client referred for further screening (Circle all that apply): TB testing, HIV testing, STD testing

Nurse (Print): _____ Signature: _____ Date: _____

Physician (Print): _____ Signature: _____ Date: _____