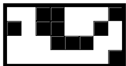

45596

Health Appraisal Questionnaire

Please Print Legibly

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MALE

Is your name and other information above correct? .... Y ◯ N ◯
(If not, please make corrections)

Please fill in your Social Security Number:

_________--_________--_________

If you have an E-Mail address, please enter it here:
____

Note your appointment times.
First appointment:

Second appointment:

WELCOME

The complete medical evaluation which you are about to receive at the Health Appraisal division of Kaiser Permanente's Department of Preventive Medicine has three major components: medical history, laboratory tests, and direct physical examination. Of these, the medical history is the most important. This questionnaire is likely to be the most detailed collection of medical information you will ever have experienced.

Please answer each question by blackening the appropriate oval with a black ball point pen. Your effort doing this well will take about 20 minutes and is the basis of our understanding your health.

Vincent J. Felitti, MD

Please mark bubbles completely, like this: ●
Not like this: ☒ ✓ ⦶

DEMOGRAPHICS AND HEREDITY

A) Have you become a member of Kaiser Permanente within the past 6 months? ◯ Y ◯ N

B.) What is your ancestry? Please fill in each circle for which your ancestry is 25% or greater:

◯ White, not of Hispanic origin ◯ Hispanic ◯ American Indian ◯ Vietnamese
◯ Black, not of Hispanic origin ◯ Asian ◯ Pacific Islander

C.) In what country were you born? ◯ United States ◯ Mexico ◯ Canada ◯ England ◯ Russia
◯ Other:

D.) What type of work do you do?

E.) Are you retired? ◯ Yes ◯ No
If yes, what type of work did you do?

F.) Have you ever worked as a Peace Officer, Fireman, Forest Ranger, or Game Warden? ◯ Y ◯ N

G.) Please list your hobbies, sports, and activities.

H.) I am currently: ◯ married ◯ separated ◯ divorced ◯ widowed ◯ never married

I.) I have been married: ◯ 0 times ◯ 1 time ◯ 2 times ◯ 3 or more times

J.) I am currently: ◯ living alone ◯ living with a companion ◯ living with family ◯ living with my spouse

K.) What do you consider your main health problem?

L.) Please note any other matters you would like to discuss.

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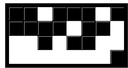

63020

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Health Appraisal Questionnaire

EDUCATION

1.) My highest level of education is: ○ elementary school ○ some high school ○ high school diploma or GED ○ some college ○ college degree ○ post-graduate degree

GENERAL HEALTH

1.) My health: ○ allows full activity. ○ limits activity to some degree.

This limitation is mostly due to: *(Fill in all that apply)*

○ pain or stiffness in joints
○ fatigue, tiredness, or lack of energy
○ shortness of breath or difficulty breathing
○ depression or feeling blue
○ heart problems including chest pain
○ other reasons

2.) I consider the amount of stress I am under to be: ○ small ○ moderate ○ large ○ overwhelming

3.) In the past 12 months, I have been to a doctor about: ○ 0 times ○ 1 - 4 times ○ 5 - 9 times ○ 10 or more times

4.) In the past 12 months, I have had to stay overnight in the hospital: ○ 0 times ○ 1 time ○ 2 or more times

5.) I regularly use seat belts in a car: ○ Y ○ N

6.) I believe I am more tired or have less energy compared to other people my age: ○ Y ○ N

7.) I currently have severe fatigue, extreme tiredness, or exhaustion: ○ Y ○ N

a.) If **yes**, when did this begin? month ☐☐ year ☐☐

b.) If **yes**, does your fatigue improve with rest? ○ Y ○ N

I often:	Y	N
8.) have trouble falling asleep or staying asleep.	○	○
9.) awaken tired after adequate sleep.	○	○
10.) fall asleep at inappropriate times.	○	○
11.) am more sensitive than other people.	○	○
12.) am anxious or nervous.	○	○
13.) am worried about being ill.	○	○
14.) am irritable.	○	○
15.) feel like crying.	○	○
16.) feel hopeless or down in the dumps.	○	○
17.) have problems with depression.	○	○
18.) feel suicidal.	○	○

I have:	Y	N
19.) difficulty saying ***No,*** or sticking up for myself.	○	○
20.) problems controlling anger.	○	○
21.) difficulty caring for myself.	○	○
22.) frequent headaches.	○	○

a.) If ***Yes,*** headaches have been present for... ○ Weeks ○ Months ○ Years

I am having serious problems with:	Y	N
23.) my marriage.	○	○
24.) my family.	○	○
25.) my job.	○	○
26.) finances.	○	○
27.) drug or alcohol use.	○	○
28.) work related injuries.	○	○

	Y	N
29.) Have you used street drugs?	○	○
30.) Do you want an HIV (AIDS) test?	○	○
31.) Are there special circumstances where you are panicked?	○	○
32.) Do you have an Advance Directive (Living Will, Durable Power of Attorney for Health Care, or Directive to Physicians)?	○	○
33.) Do you read easily?	○	○

NEUROLOGICAL

Have you had or do you have:	Y	N
1.) trouble with your balance?	○	○
2.) a fall within the past year?	○	○
3.) trouble walking?	○	○
4.) trouble remembering?	○	○
5.) problems with dizziness?	○	○
6.) ever been knocked unconscious?	○	○
7.) involuntary movements of your body?	○	○
8.) a convulsion or seizure?	○	○
9.) some numbness in your hands or feet?	○	○
10.) a hand or foot paralysis for > 5 min?	○	○
11.) a temporary loss of speech?	○	○
12.) a temporary loss of vision?	○	○
13.) a stroke?	○	○
14.) hallucinations at times?	○	○
15.) a nervous breakdown?	○	○
16.) a brain, nerve, or emotional problem not on this list?	○	○

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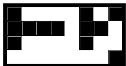

63108

Health Appraisal Questionnaire

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EYES

Have you had or do you have:

	Y	N
1.) blurred vision not corrected by glasses?	○	○
2.) double vision? (not blurred)	○	○
3.) visual spots / floaters?	○	○
4.) color blindness?	○	○
5.) a spot in your vision?	○	○
6.) a sudden loss of vision?	○	○
7.) a blind eye?	○	○
8.) a glass eye?	○	○
9.) itchy eyes?	○	○
10.) eye pain?	○	○
11.) cataracts?	○	○
12.) a retinal hemorrhage?	○	○
13.) macular degeneration?	○	○
14.) a detached retina?	○	○
15.) glaucoma or borderline glaucoma?	○	○
16.) an eye problem not on this list?	○	○

EARS

Have you had or do you have:

	Y	N
1.) trouble hearing?	○	○
2.) prolonged exposure to loud noise?	○	○
3.) tinnitus (ringing) in only one ear?	○	○
4.) tinnitus in both ears?	○	○
5.) a hearing aid that you use?	○	○
6.) frequent ear infections?	○	○
7.) a draining ear?	○	○
8.) a serious ear injury?	○	○
9.) an ear problem not on this list?	○	○

NOSE\SINUSES

Have you had or do you have:

	Y	N
1.) hay fever or allergic rhinitis?	○	○
2.) frequent sneezing, watering, or nasal congestion?	○	○
3.) colored mucus often draining from your nose?	○	○
4.) frequent nosebleeds?	○	○
5.) nasal polyps?	○	○
6.) nasal problem not on this list?	○	○

MOUTH, THROAT, NECK

Have you had or do you have a:

	Y	N
1.) lip problem?	○	○
2.) tooth or gum problem?	○	○
3.) mouth, tongue, or jaw problem?	○	○
4.) thyroid disease?	○	○
5.) swallowing problem?	○	○
6.) voice problem?	○	○
7.) problem with back of your throat?	○	○
8.) lump or swelling in neck?	○	○
9.) neck pain?	○	○
10.) a mouth, throat, or neck problem not on this list?	○	○

LUNGS

Have you had or do you have:

	Y	N
1.) wheezing?	○	○
2.) shortness of breath?	○	○
3.) a chronic cough?	○	○
4.) an episode of coughing up blood in the past year?	○	○
5.) asthma?	○	○
6.) emphysema?	○	○
7.) repeated episodes of pneumonia?	○	○
8.) tuberculosis?	○	○
9.) pulmonary embolism (blood clot in lung)?	○	○
10.) chronic bronchitis?	○	○
11.) collapsed lung?	○	○
12.) sarcoid?	○	○
13.) frequent night sweats?	○	○
14.) a lung or chest problem not listed?	○	○

I have:

15.) been a cigarette smoker. ○ ○

If **yes**:

a.) Do you currently smoke? ○ ○

b.) If **yes**, how many cigarettes do you now smoke per day? ☐☐☐

c.) If **yes**, How many years have you smoked? ☐☐

16.) used other tobacco products. (Y) ○ (N) ○

a.) If **yes**, which: ○ Cigars ○ Pipe ○ Snuff ○ Chewing Tobacco

b.) Are you currently using these products? ○ ○

c.) If **yes**, how many times per day? ☐☐

I have:

	Y	N
17.) received BCG vaccine (TB immunization).	○	○
18.) had a positive TB skin test.	○	○
19.) taken INH for at least 6 months.	○	○
20.) received Pneumovax (pneumonia vaccine).	○	○

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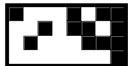

11591

Health Appraisal Questionnaire

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CARDIO-VASCULAR

Have you had or do you have:

	Y	N
1.) high blood pressure?	O	O
a.) If **yes**, do you take medication?	O	O
2.) a cholesterol problem?	O	O
a.) If **yes**, do you take medication?	O	O
3.) a heart valve problem?	O	O
4.) an abnormal treadmill test?	O	O
5.) a coronary arteriogram?	O	O
6.) angina pectoris (heart pains)?	O	O
a.) If **yes**, do you take nitroglycerin?	O	O
7.) a silent heart attack?	O	O
8.) a heart attack for which you were hospitalized more than 3 days?	O	O
9.) a 'clot buster' treatment for a heart attack?	O	O
10.) congestive heart failure?	O	O
11.) abnormal blood clot formation?	O	O
12.) varicose veins?	O	O
13.) intermittent claudication?	O	O
14.) narrowing of the arteries in your neck?	O	O
15.) a heart or circulatory problem not listed here?	O	O

Do you get:

16.) pressure or tightness in your chest, with exertion or walking uphill? O Y O N

a.) If **yes,** does the pain: O allow for continuation of activity? O force you to stop what you are doing? O force you to slow down? O go away within 5 minutes of stopping? O occur while you walk on flat ground?

b.) If **yes,** does the pain spread? O Y O N

c.) If **yes,** does it spread to your: O neck or jaw? O inner left arm? O outer left arm? O wrist or forearm? O stay only in the chest? O another part of the body?

17.) pain in the legs that forces you to stop walking? O Y O N

a.) If **yes,** do these leg pains or cramps O come on at the same distance each time, on flat ground? O come on faster on hills? O come on faster when walking rapidly? O go away within a minute or so of stopping?

18.) episodes of rapid or irregular heartbeat? O Y O N

a.) If **yes,** do these episodes last for: O seconds? O minutes? O hours?

b.) If **yes,** is your heartbeat: O at its usual speed, but irregular? O much faster than usual and irregular? O much faster than usual and perfectly regular? O not possible to describe?

c.) If **yes,** heartbeat goes back to normal: O slowly without noticing? O abruptly and noticeably? O not sure?

19.) Have you ever donated blood for transfusions? O Y O N

a.) If **yes,** how many times in the last year have you donated? O 0 O 1 O 2 O 3 O 4+

b.) How many times have you donated blood in your lifetime? O 1-10 O 11-19 O 20-30 O 31-100 O 100+

20.) Have you ever had abnormal blood clots develop? O Y O N

a.) If **yes,** blood clots developed in my: O lungs O deep veins of a leg O eye O veins under the skin O elsewhere

b.) These abnormal clots developed: O after a long trip O after a week or more of bedrest O within a week of surgery O within a week of injury

SKIN

I have:

	Y	N
1.) a mole that has changed color or size.	O	O
2.) loss of body hair other than scalp.	O	O
3.) a sore that doesn't heal.	O	O
4.) acne.	O	O
5.) eczema.	O	O
6.) psoriasis.	O	O
7.) allergy to medications.	O	O
8.) allergy to cosmetics or chemicals.	O	O
9.) allergy to sunlight.	O	O
10.) history of radiation treatment.	O	O
11.) darkening of the skin.	O	O
12.) a skin condition not on this list.	O	O

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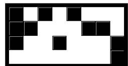

50833

Health Appraisal Questionnaire

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DIGESTIVE

During the last year I have had: (Y / N)

1.) distinct weight gain. ○ ○
2.) distinct weight loss. ○ ○
3.) trouble swallowing. ○ ○
4.) indigestion or heartburn. ○ ○
5.) recurrent nausea or vomiting. ○ ○
6.) recurrent abdominal pain. ○ ○
7.) an episode of vomiting blood. ○ ○
8.) a change in bowel habits. ○ ○
9.) frequent diarrhea. ○ ○
10.) chronic constipation. ○ ○
11.) visible blood in bowel movement. ○ ○
12.) black, tar like, bowel movements. ○ ○
13.) inability to control my bowels. ○ ○
14.) digestion problems not on this list. ○ ○

I have been diagnosed by a doctor with: (Y / N)

15.) esophagitis or esophageal reflux. ○ ○
16.) hiatal hernia. ○ ○
17.) liver trouble. ○ ○
18.) gall bladder problems. ○ ○
19.) peptic ulcer. ○ ○
20.) gastro-intestinal bleeding. ○ ○
21.) irritable bowel syndrome. ○ ○
22.) intestinal polyps. ○ ○
23.) abdominal hernia (rupture). ○ ○
24.) hemochromatosis. ○ ○
25.) hepatitis. ○ ○
26.) borderline diabetes. ○ ○
27.) diabetes. ○ ○
If **yes,**
a.) Do you take pills to reduce blood sugar? ○ ○
b.) Do you take Insulin? ○ ○
c.) If **yes**, age when you started taking Insulin: ○ < 10 ○ 11 - 15 ○ 16 - 25 ○ 26 - 50 ○ > 51
28.) a gastro-intestinal problem not on the list. ○ ○

In the past ten years I have a had a:

29.) barium enema. ○ ○
30.) colonoscopy. ○ ○
31.) sigmoidoscopy. ○ ○

I am: (Y / N)

32.) a vegetarian. ○ ○
33.) a strict vegetarian who avoids all animal products including fish and dairy. ○ ○
34.) likely to have some form of alcohol:
○ never. ○ hardly ever.
○ fewer than 3 times per week.
○ more than 3 times per week. ○ Daily.
35.) When I do have alcohol it is usually:
○ 1 - 2 drinks/day. ○ 3 - 4 drinks/day.
○ over 4 drinks/day
36.) I sometimes wonder if I drink more than is good for me. ○ ○
37.) Was there ever a time when you often drank 5 or more drinks a day of any kind of alcoholic beverage? ○ ○

SURGERY

Have you had any of the following surgical operations: (Y / N)

1.) prostate surgery? ○ ○
2.) vasectomy? ○ ○
3.) abdominal aortic aneurysm? ○ ○
4.) angioplasty? ○ ○
5.) appendectomy? ○ ○
6.) cataract? ○ ○
7.) cholecytectomy-gall bladder? ○ ○
8.) coronary bypass? ○ ○
9.) carpal tunnel release? ○ ○
10.) ear surgery? ○ ○
11.) heart valve replacement? ○ ○
12.) hernia repair? ○ ○
13.) kidney surgery? ○ ○
14.) peptic ulcer surgery? ○ ○
15.) thyroid surgery? ○ ○
16.) tonsillectomy? ○ ○
17.) artificial joint implant? ○ ○
18.) disk or other back surgery? ○ ○
19.) other bone surgery? ○ ○
20.) surgery not on this list? ○ ○
21.) Have you ever been diagnosed with cancer? ○ ○
If **yes**, select which:
22.) lung? ○ ○
23.) blood or lymphatics? ○ ○
24.) bladder? ○ ○
25.) colon? ○ ○
26.) skin? ○ ○
27.) breast? ○ ○
28.) testicle? ○ ○
29.) prostate? ○ ○
30.) any other cancer? ○ ○

MEDICATIONS

Do you regularly take any of the following medications: (Y / N)

1.) Advil or Motrin? ○ ○
2.) antacids? ○ ○
3.) anticoagulants? ○ ○
4.) aspirin? ○ ○
5.) diuretics? ○ ○
6.) thyroid? ○ ○
7.) herbal medications? ○ ○
8.) laxatives? ○ ○
9.) Tylenol? ○ ○
10.) Coumadin ○ ○
11.) Hytrin ○ ○
12.) HCTZ ○ ○
13.) Imipramine ○ ○
14.) Lisinopril ○ ○
15.) Naprosyn ○ ○
16.) Niacin ○ ○
17.) Nitrostat ○ ○
18.) Optipranolol ○ ○
19.) Potassium ○ ○
20.) Prednisone ○ ○
21.) Proventil ○ ○
22.) Prozac ○ ○
23.) Sulindac ○ ○
24.) Testosterone ○ ○
25.) Viagra ○ ○
26.) Zestril ○ ○
27.) Zantac ○ ○

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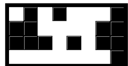

50155

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Health Appraisal Questionnaire

MEDICATIONS

28.) Please list all prescription medications not previously listed that you take regularly:

29.) Please list all non prescription or over the counter medications not previously listed that you take regularly:

MEN'S HEALTH

I have had: Y N

1.) prostatitis. ○ ○
2.) urethritis. ○ ○
3.) pyelonephritis. ○ ○
4.) nephritis or glomerulonephritis (Bright's Disease). ○ ○
5.) a kidney stone. ○ ○
6.) genital herpes. ○ ○
7.) gonorrhea. ○ ○
8.) syphilis. ○ ○
9.) other sexually transmitted disease. ○ ○

I currently have:

10.) problems starting or stopping urine. ○ ○
11.) occasional loss of urine. ○ ○
12.) reduced urine stream. ○ ○
13.) to get up several times each night to urinate. ○ ○
14.) pain or burning with urination. ○ ○
15.) blood in urine. ○ ○
16.) problems getting an erection. ○ ○

I currently have: Y N

17.) problem with impotence or maintaining an erection during sex. ○ ○
18.) a urinary, sexual, or men's health problem not on this list. ○ ○

I am:

19.) not sexually active for the past year. ○ ○
20.) no longer sexually active. ○ ○
21.) sexually active with a female partner. ○ ○
22.) sexually active with a male partner. ○ ○
23.) sexually active with more than one partner. ○ ○
24.) satisfied with my sex life. ○ ○
25.) taking Viagra. ○ ○
26.) possibly at risk for AIDS. ○ ○
27.) diagnosed with HIV / AIDS. ○ ○
28.) practicing male birth control. ○ ○
a.) If **yes**, ○ condoms ○ vasectomy

I have:

29.) been physically abused as a child. ○ ○

I have: Y N

30.) been verbally abused as a child. ○ ○
31.) been sexually molested as a child or adolescent. ○ ○
32.) been raped. ○ ○
33.) been threatened or abused as an adult by a sexual partner. ○ ○
34.) Has your partner ever threatened, pushed, or shoved you? ○ ○
35.) Have you ever threatened, pushed, or shoved your partner? ○ ○
36.) Have you ever had a partner threaten or abuse your children? ○ ○

Have you ever:

37.) been rejected for the armed forces? ○ ○
38.) been rejected for life insurance? ○ ○
39.) been a combat soldier? ○ ○
40.) lived in a war zone? ○ ○

MUSCULO-SKELETAL

I have had: Y N

1.) a leg fracture. ○ ○
2.) a fracture of the pelvis. ○ ○
3.) 3 or more fractures in my life. ○ ○
4.) a fracture other than listed. ○ ○
5.) a bone or ligament injury that never healed. ○ ○
6.) Polio. ○ ○

I currently have: Y N

7.) nocturnal leg cramps. ○ ○
8.) pain or stiffness in my joints on most days. ○ ○
a.) If **yes:**
○ < 6 mos. ○ 6 - 12 mos. ○ > 1 yr.
9.) a musculo-skeletal problem not on this list. ○ ○

I have been diagnosed with:

10.) rheumatoid arthritis. ○ ○

I have been diagnosed with: Y N

11.) osteoarthritis. ○ ○
12.) psoriatic arthritis. ○ ○
13.) other forms of arthritis. ○ ○
14.) osteoporosis. ○ ○
15.) gout. ○ ○
16.) hemochromatosis. ○ ○
17.) lupus. ○ ○
18.) fibrositis or fibromyalgia. ○ ○

HOSPITALIZATIONS AND SERIOUS ILLNESS

1.) Please list all medical and psychiatric hospitalizations not previously mentioned.

2.) Please list any serious illnesses for which you were not hospitalized and that have not been previously mentioned.

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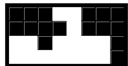

63265

Health Appraisal Questionnaire

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FAMILY HISTORY

1.) I have this many brothers and sisters: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ > 10

2.) I am:
a.) adopted. ○ Y ○ N
b.) an identical twin. ○ Y ○ N
c.) aware of the health of my biological family. ○ Y ○ N
d.) in contact with all my living family of origin. ○ Y ○ N

3.) My spouse has serious health or emotional problems. ○ Y ○ N

4.) One of my children has serious health or emotional problems. ○ Y ○ N

5.) Some primary members of my family died before age of 65. ○ Y ○ N

6.) Fill in only the circles that are appropriate. The following have occurred in my biological family:	Mother	Father	Brothers	Sisters	Children	Grandparents
Heart attack before age 60	○	○	○	○	○	○
Abnormal blood clots	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○
Alcoholism	○	○	○	○	○	○
Street or Illegal Drug Use	○	○	○	○	○	○
Hemochromatosis	○	○	○	○	○	○
Cirrhosis	○	○	○	○	○	○
Arthritis	○	○	○	○	○	○
Nervous Breakdown	○	○	○	○	○	○
Any rare hereditary disease	○	○	○	○	○	○
Suicide	○	○	○	○	○	○
Murder	○	○	○	○	○	○
Serious health or emotional problem	○	○	○	○	○	○

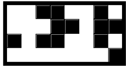
7.) Are there any additional diseases which have occurred in your family that have not been listed? If **yes**, please print diseases and who had them.

Disease | Relationship

Disease | Relationship

Disease | Relationship

Continued on other side



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Health Appraisal Questionnaire

Office Use Only

PART 1 REVIEW

Please fill in the appropriate oval.	**Y**	**N**
A.) Do you have trouble hearing?	○	○
B.) Do you have ringing in your ears (tinnitus)?	○	○
C.) Have you been exposed to loud noises?	○	○
D.) Have you had a positive reaction to a TB Test?	○	○
E.) Have you been treated for TB or Coccidioidomycosis (Valley Fever)?	○	○
F.) Have you ever had a chest X-ray at Kaiser?	○	○
If **yes**, about when: ☐☐ *Year*		
G.) Do you have high blood pressure?	○	○
H.) Do you take blood pressure medicine?	○	○
I.) Do you take diuretics? (Water Pills)	○	○
J.) Do you take thyroid medication?	○	○
K.) Have you ever had a heart attack?	○	○
L.) Do you get pains or heavy pressure in your chest with exertion?	○	○
M.) Do you get episodes of fast heart beats or skipped beats?	○	○
N.) Do you smoke cigarettes now?	○	○
O.) Do you take medicine to lower your cholesterol?	○	○
P.) Have you ever been diagnosed with Angina Pectoris?	○	○
Q.) Do you have any other heart problems?	○	○
R.) Have you ever had an EKG at Kaiser?	○	○
If **yes**, about when: ☐☐ *Year*		
S.) Are you diabetic?	○	○
T.) When was your last eye exam, approximately? ☐☐ *Year*		
U.) Do you want an HIV (AIDS) blood test?	○	○
V.) Do you need this physical for a special purpose?	○	○
If **yes**, for DMV?	○	○
for weight management?	○	○
W.) Do you have an allergy to any medications?	○	○

If yes, which:

33985

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Health Appraisal - Vital Signs

Name: ____________________

Date: [ ][ ] / [ ][ ] / [ ][ ]
Month *Day* *Year*

MRN#: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Age: [ ][ ] **Temperature:** [ ][ ][ ] . [ ] ° F **Height:** [ ][ ] *Inches* **Weight:** [ ][ ][ ] *Lbs.*

B/P: [ ][ ][ ] / [ ][ ][ ] *mm Hg* **Pulse:** [ ][ ][ ] */ min* ○ Irregular

B/P #2: [ ][ ][ ] / [ ][ ][ ] *mm Hg* **Pulse #2:** [ ][ ][ ] */ min* ○ Irregular

Visual Accuity: ○ Uncorrected **Corrected:** ○ Glasses ○ Contacts **Needs Retinal Photo?** ○ Y ○ N

	Far	*Pinhole*	*Tonometry:* 1.)	2.)	3.)
BOTH:	20/ [ ][ ][ ]	20/ [ ][ ][ ]	[ ][ ] OD	[ ][ ] OD	[ ][ ] OD
OD:	20/ [ ][ ][ ]	20/ [ ][ ][ ]	[ ][ ] OS	[ ][ ] OS	[ ][ ] OS
OS:	20/ [ ][ ][ ]	20/ [ ][ ][ ]			

Reads Text? ○ Y ○ N

Best Vital Capacity: [ ][ ][ ][ ] cc *Best FEV1:* [ ][ ][ ][ ] cc

	Y	N		Y	N
Tine Test given:	○	○	*Audiometry performed:*	○	○
Needs PPD:	○	○	*CXR done:*	○	○
Clock face test performed:	○	○	*Mammo done:*	○	○
Fasting > 2 hrs:	○	○	*Labs drawn:*	○	○
Hemoccult given:	○	○	*EKG done:*	○	○

Health Assistant's Initials: [ ][ ]

Agrees to participate in HC study? Y ○ N ○

Health Assistant's Initials: [ ][ ]

HC study labs drawn? Y ○ N ○

Clock Face Test

Health Assistant Notes