NYC DOC Intake History and Physical Exam

DIVISION OF HEALTH CARE ACCESS & IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

INTAKE
HISTORY AND PHYSICAL EXAM

PLACE MEDICAL LABEL HERE

Patient's Last Name | First Name

Book & Case Number | NYSID Number

DATE | TIME ❑ AM ❑ PM | FACILITY | HAVE YOU PREVIOUSLY BEEN INCARCERATED? ❑ YES ❑ NO If yes, where? ❑ RIKERS ❑ ELSEWHERE: _____ If yes, when? | DO YOU HAVE MEDICAID OR ANY HEALTH INSURANCE? ❑ YES ❑ NO WHERE DO YOU CURRENTLY GET MEDICAL CARE?

1. DO YOU HAVE ANY ALLERGIES? ❑ YES ❑ NO | Reaction Type ❑ HIVES ❑ RASH ❑ SOB ❑ ANAPHYLAXIS ❑ DON'T KNOW | ALLERGIES TO MEDICATIONS? | OTHER

2. HAVE YOU EVER HAD HIGH BLOOD SUGAR OR DIABETES? ❑ YES ❑ NO I F YES, ❑ TYPE-1 ❑ TYPE-2 | FINGER STICK (ON ADMISSION)

3. HAVE YOU EVER HAD TB? ❑ YES ❑ NO Where diagnosed?

Do you have? Weight loss ❑ YES ❑ NO; Night Sweats ❑ YES ❑ NO; Fever ❑ YES ❑ NO; Cough > 2 Wks ❑ YES ❑ NO

Chest X-ray done? ❑ YES ❑ NO If yes, ❑ Normal ❑ Abnormal When? ___/___/___

Current and Past TB Medications Taken? | How long taken?

4. HAVE YOU EVER HAD:
- Multiple Sex partners? ❑ YES ❑ NO
- Unprotected sex? ❑ YES ❑ NO
- Sex with substance abusers? ❑ YES ❑ NO
- Same sex relationship? ❑ YES ❑ NO
- I.V. Drug Use? ❑ YES ❑ NO

HAVE YOU EVER HAD:
- Syphilis? ❑ YES ❑ NO
- Gonorrhea? ❑ YES ❑ NO
- Chlamydia? ❑ YES ❑ NO
- Hepatitis A? ❑ YES ❑ NO
- Hepatitis B? ❑ YES ❑ NO
- Hepatitis C? ❑ YES ❑ NO
- Any current tx ? ❑ YES ❑ NO

Did you watch the HIV Video? ❑ YES ❑ NO
Did you read the HIV Brochure? ❑ YES ❑ NO

Do you have HIV Infection or AIDS? ❑ YES ❑ NO *(If yes, complete HIV Flow Sheet)*

5. RAPID HIV TEST
- ❑ Wants Rapid HIV Test
- ❑ Declines HIV Testing
- ❑ Undecided
- ❑ Confirmatory
- ❑ Retest

REASONS FOR DECLINING RAPID HIV TEST
- ❑ Known HIV Positive
- ❑ Prefer Conventional Test
- ❑ Had Negative HIV Result ,< 3 months ago
- ❑ Not Ready to get test results today
- ❑ Don't want test now/today
- ❑ Other

HIV Ab Testing done? ❑ YES ❑ NO When?

Viral Load ❑ YES ❑ NO #_____ When?

Latest T-Cell (CD4) #_____ When?

6. EVER HAD ASTHMA? ❑ YES ❑ NO | Last ER Visit? Last Attack? Ever Admitted? ❑ YES ❑ NO | Ever Intubated? ❑ YES ❑ NO When? ___/___/___

7. EVER HAD HYPERTENSION? ❑ YES ❑ NO

8. DO YOU HAVE: ❑ PND ❑ SOB ❑ Palpitations ❑ DOE ❑ Pedal Edema

Chest Pain? ❑ YES ❑ NO When? ___/___/___

Syncope? ❑ YES ❑ NO When? ___/___/___

Family history of sudden death under age 55? ❑ YES ❑ NO

Ever had Heart Disease? ❑ YES ❑ NO

Ever had a heart attack? ❑ YES ❑ NO When? ___/___/___

9. HAVE YOU HAD A PAP SMEAR IN THE LAST 12 MONTHS? ❑ YES ❑ NO ❑ N/A If yes, When? ___/___/___

10. DO YOU USE DRUGS ❑ YES ❑ NO DRUG AMOUNT:

If yes, check drugs, and complete the "Opiod Withdrawal Assessment Form"
Drugs used: ❑ HEROIN ❑ BARBITUATES ❑ MARIJUANA ❑ CRACK ❑ COCAINE ❑ CRYSTAL METH ❑ METHADONE ❑ OTHER:

If you have answered "YES" to any question and require additional space, please use the Additional Comments area on Page 4.

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11. ARE YOU CURRENTLY IN A METHADONE PROGRAM? ❑ YES ❑ NO	Where? Dose _____	12. DO YOU USE ALCOHOL? ❑ YES ❑ NO AMOUNT:	Have you considered cutting down drinking? ❑ YES ❑ NO Annoyed by people asking about your drinking? ❑ YES ❑ NO Ever had guilty feelings about your drinking? ❑ YES ❑ NO Ever needed a drink as an "eye opener"? ❑ YES ❑ NO	When last drink or drug use?
13. ANY ADDITIONAL MEDICAL PROBLEMS? ❑ YES ❑ NO		List		
14. TREATED OR HOSPITALIZED FOR NERVOUS / MENTAL PROBLEMS? ❑ YES ❑ NO When?	Where? Why?	15. ARE YOU TAKING MEDICATION FOR NERVES/MENTAL PROBLEMS? ❑ YES ❑ NO	Medications / Dosage:	
16. HAVE YOU TRIED TO HURT OR KILL YOURSELF? ❑ YES ❑ NO When?	How? Why?	17. HAVE YOU EVER BEEN ASSAULTED (SEXUALLY/PHYSICALLY)? ❑ YES ❑ NO	18. HAVE YOU BEEN CHARGED WITH A VIOLENT ACT (RAPE, ASSAULT)? ❑ YES ❑ NO	
19. HAVE YOU HURT ANYONE WHEN YOU WERE ANGRY OR UPSET? ❑ YES ❑ NO	When? Who?	How? Why?		
20. HAVE YOU EXPERIENCED ANY RECENT LOSSES? (i.e., death, employment, relationships, etc) ❑ YES ❑ NO	Explain			

SUMMARY OF CURRENT MEDICATIONS *(Please List)*

21. CHARGES REVIEWED?
❑ YES ❑ NO

COMPLETED BY (*Print Name*) _____ REVIEWED BY: _____

Signature of person completing form | Title | Date | Time

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NYC Health

DIVISION OF HEALTH CARE ACCESS & IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

PHYSICAL EXAMINATION

Last Name	First Name	Temp
Snellen w/o correction R _____ L _____ w correction R _____ L _____	Ht	Pulse / RR
VSS Taken by *(Full Name)*	Wt	Peak Flow
Signature		BP

GENERAL APPEARANCE: *(Include body habitus, nutritional status, and state of distress.)*

HEENT
❑ Scalp lesions ❑ NL ❑ Abnormal Pupils ❑ Traumatic ❑ Conjunctivitis ❑ Lacerations ❑ Pale sclera ❑ Icteric ❑ Other

SKIN *Describe*
❑ NL ❑ Jaundice ❑ Rash ❑ Tattoos ❑ Pallor ❑ Tracks ❑ Scars ❑ Other

ORAL CAVITY
❑ Filled cavities *Describe* ❑ NL ❑ Dentures loose ❑ Lesions ❑ Missing teeth ❑ Swellings ❑ Other

BREASTS *Describe*
❑ NL ❑ Discharge ❑ Masses ❑ Other

CHEST *Describe*
❑ NL ❑ Rubs ❑ Wheezing ❑ Rhonchi ❑ Rales ❑ Other

HEART *Describe*
❑ NL / RRR ❑ Murmur ❑ Gallop ❑ Rub ❑ Other

FUNDUS
❑ Normal ❑ Not Visualized ❑ Other

OTOSCOPIC

LYMPH NODES

NECK THYROID
❑ NL ❑ Carotid Bruit ❑ Thyroid enlargement/mass

ABDOMEN *Describe*
❑ NL ❑ Ascites ❑ Tenderness ❑ Other ❑ Hypo/Hyperactive Bowel sounds ❑ Organomegaly

GENITALIA *Describe*
❑ Lesions ❑ Sores ❑ Warts ❑ Discharge ❑ Other

PELVIC EXAM *(Adnexa, Uterus)* *Describe*
❑ N/A ❑ Refused ❑ NL ❑ Adnexal Mass ❑ Discharge from Cervix ❑ Tenderness ❑ Uterine Mass ❑ Other

PAP SMEAR *Describe*
❑ Performed ❑ Refused ❑ Chlamydia/Gonorrhea Test ❑ Deferred ❑ Culture ❑ Other *(Describe)*

RECTAL
❑ NL ❑ Not Indicated PT less than 40 yrs old ❑ Hemorrhoids ❑ Sores ❑ Fissures ❑ Refused ❑ Warts ❑ Other

EXTREMITIES
❑ NL ❑ Pulse ❑ Edema ❑ Clubbing ❑ Cyanosis ❑ Other

MENTAL STATUS

ORIENTATION TO
❑ Time ❑ Place ❑ Person

PSYCHOMOTOR
❑ WNL ❑ Retardation ❑ Agitation

SPEECH
❑ Coherent ❑ Incoherent ❑ Normal Rate ❑ Pressured ❑ Spontaneous

MOOD
❑ Euthymic ❑ Irritable ❑ Anxious ❑ Elated ❑ Depressed ❑ Angry ❑ Embarrased/Humiliated

AFFECT
❑ Appropriate to mood ❑ Inappropriate to mood ❑ Labile

THOUGHT PROCESS
❑ Logical ❑ Illogical ❑ Relevant ❑ Irrelevant

ANY PROBLEMS WITH SLEEP OR APPETITE OR ANY FEELINGS OF HOPELESSNESS OR BEING WORTHLESS?
❑ YES ❑ NO

SUICIDAL IDEATION? ❑ YES ❑ NO

HOMICIDAL IDEATION? ❑ YES ❑ NO

DELUSIONS
❑ None ❑ Grandiose (Do you have special abilities or features?) ❑ Persecution (Do you feel anyone is plotting against you?) ❑ Somatic ❑ Other

HALLUCINATIONS Does patient exhibit any?
❑ None ❑ Auditory ❑ Visual

DOES PT EXHIBIT ANY SIGNS OF GROSS MENTAL RETARDATION?
❑ YES ❑ NO

NEUROLOGIC *(Sensory, Motor, DTR, Gait, Cerebellar, Cranial Nerves)* **DESCRIBE** *(If abnormal, give details in assessment)*

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ADDITIONAL COMMENTS *(Please Include Question Number with each Additional Comments Section*

ASSESSMENT	PLAN

URINE PREGNANCY

- ❑ N/A
- ❑ Positive
- ❑ Negative

URINE DIP/KETONES *(ON ADMISSION)*

❑ YES ❑ NO

DISPOSITION

❑ Medical Isolation Reason:

❑ Detox

HOUSING : ❑ GP ❑ CDU ❑ INFIRMARY ❑ C-71 ❑ MO ❑ OTHER:

CONSULTS: ❑ URGICARE ❑ ER/HOSPITAL ❑ MH EMERGENCY ❑ MH ROUTINE ❑ OTHER:

BROCHURES GIVEN?

- REACH HIV-STD ❑ YES ❑ NO
- Health Information ❑ YES ❑ NO
- Dental Brochure ❑ YES ❑ NO

SIGNATURE	DATE/TIME
PRINT NAME	TITLE

REVIEWED BY:

PRINT NAME	SIGNATURE	DATE/TIME

Please use the Additional Comments area on the top of this page for any "YES" question requiring additional space.

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