

### Medical Assessment

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M / F

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Accompanied by: \_\_\_\_\_ Primary Doctor: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason for last visit: \_\_\_\_\_ Allergies

(include medications, food, contrast, environmental): \_\_\_\_\_

Current medications (include name, dose, time of day taken)-include over the counter medications:

- |          |           |
|----------|-----------|
| 1. _____ | 8. _____  |
| 2. _____ | 9. _____  |
| 3. _____ | 10. _____ |
| 4. _____ | 11. _____ |
| 5. _____ | 12. _____ |
| 6. _____ | 13. _____ |
| 7. _____ | 14. _____ |

Any medication changes in the past 7 days? Y / N

Are you taking your medications as prescribed? Y/ N

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Do you have anything notable with your skin? (scars, cuts, wounds, tattoo's, piercing's) Y / N

If yes, explain: \_\_\_\_\_

Do you have problems breathing? (asthma, shortness of breath, oxygen use, colds) Y / N

If yes, explain: \_\_\_\_\_

Have you recently had any of the following?

Coughing Y / N    Fever Y / N    Night sweats Y / N    Unexplained weight loss Y / N

If yes, explain: \_\_\_\_\_

Do you drink alcohol or use illegal drugs? Y / N

If yes, last date/time used: \_\_\_\_\_ Amount used/drank: \_\_\_\_\_

**DOMINION HOSPITAL**

Patient Information/Label

