AdaCountyParamedics
Community Paramedic

General Health Assessment form Completed by:

Pt name: **Pt ID #:** **Date:** / /

Vaccine / Immunization

Pneumonia	Influenza	Tetanus	Pediatric
Within 5 years 65 or older Unknown	This year Unknown Under 13 vaccinated	Date last given: _____ Unknown	Up-to-date Unknown

Additional Forms

Med Rec	CHF	Asthma / COPD	Diabetes	Wound Care	Fall Risk

Social Hx

ETOH (CAGE)	Tobacco	Illicit drug
1. Have you ever felt the needs to cut down on drinking? Y N 2. Do you feel annoyed by people complaining of your drinking? Y N 3. Do you feel guilty about your drinking? Y N 4. Do you ever drink an eye-opener in the morning to relieve shakes? Y N **Two or more affirmative responses suggest that the Pt. is a problem drinker.** Is the Pt. interested in quitting or counseling? Y N	**Cigarettes Use** Never Yes-Pk per day___ Quit date _____ **Other** Pipe Cigar Snuff Chew Interested in quitting Y N	Do you use any recreational drugs? Y N Ever used needles to inject drugs? Y N

Oral Health Assessment Tool for Dental Screening

Scoring: You may circle individual words as well as give a score in each category

Category	0 = Healthy	1 = Changes	2 = Unhealthy	scores
Lips	Smooth, pink, moist	Dry, chapped, or red at corners	Swelling or a lump; white, red, or ulcerated patch; bleeding or ulcerated at corners	
Tongue	Normal, moist, roughness, pink	Patchy, fissured, red, coated	Patch that is red or white, ulcerated, or swollen	
Gums and tissues	Pink, moist, smooth, no bleeding	Dry, shiny, rough, red, swollen, one ulcer or sore spot under dentures	Swollen, bleeding, ulcers, white or red patches, generalized redness under dentures	
Saliva	Moist tissues, watery and free-flowing saliva	Dry, sticky tissues, little saliva present, resident reports having a dry mouth	Tissues parched and red, very little or no saliva present, saliva is thick, resident reports having a dry mouth	
Natural teeth Yes / No	No decayed or broken teeth/roots	One to three decayed or broken teeth/roots or very worn-down teeth	Four or more decayed or broken teeth/roots, very worn-down teeth, or less than four teeth are present	
Dentures Yes / No	No broken areas or teeth, dentures are worn regularly and marked with the resident's name	One broken area or tooth, dentures only worn for one or two hours daily, dentures are not marked with the resident's name, or dentures are loose	More than one broken area or tooth, dentures are missing or not worn, dentures are loose and need adhesive, or dentures are not marked with the resident's name	
Oral cleanliness	Clean; no food particles or tartar in the mouth or dentures	Food particles, tartar, or plaque on one or two areas of the mouth or on a small area of dentures, or presence of halitosis (bad breath)	Food particles, tartar, or plaque in most areas of the mouth or dentures, or presence of severe halitosis	
Dental pain	No verbal/behavioral signs (pulling at face, not eating, aggression) or physical signs (cheek or gum swelling, broken teeth, ulcers) of dental pain	Presence of verbal/behavioral signs of dental pain	Presence of physical and verbal / behavioral signs of dental pain	***Total***

❑ Pt. has a primary dentist and agrees to further evaluation. ❑ *Referral information is given to the pt. with their understanding.*

❑ *Client or family/guardian refuses dental treatment for the resident.*

Physicians / Specialist / Dentist / Outpatient services

Practitioner name	Specialty

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use a "√" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or hurting yourself	0	1	2	3
Add Columns +		+		+

Healthcare professional: For interpretation of TOTAL, please refer to accompanying score care).	**TOTAL:**	

10. If you checked off any problems, how difficulty have these Problems made it for you to do your work, take care of things at home, or get along with people?
    - ☐ Not difficulty at all
    - ☐ Somewhat Difficulty
    - ☐ Very difficulty
    - ☐ Extremely difficult

Nutritional screening

1. Do you understand how your diet food choices affect your current medical condition? • Can you tell me more about that? _____	Yes No
2. Have you received consultation about how your food choices can impact your medical condition? • What do you remember the most? _____	Yes No
3. What are your current goals regarding your food choices?	
4. How many times per week do you eat at a fast food / restaurant / take out? • Which establishments?	1-3 3-5 5-7
5. Are you able to keep your food choice goals in mind while eating at these establishments?	Yes No
6. Who does your shopping and where do they / you get your food? Who: Where:	

Current eating patterns (typical foods eaten)

Breakfast:	
Lunch:	
Dinner:	
Snacks:	
Beverages:	
7. Do you want assistance / further education regarding your food choice goals / needs or concerns?	Yes No

Pt specific concerns

_____

_____

_____

Notes

_____

_____

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_____

DRAFT