TRIMED
Home Care Services

ANNUAL HEALTH ASSESSMENT

Name: _____ Date of Birth: _____/_____/_____ Sex: M( ) F( )

Address: _____

Contact #1:(_____) _____-_____ Emergency Contact: _____ (_____)_____-_____

Please indicate if you are suffering from or have a history of the following conditions:

Condition	Yes	No	Condition	Yes	No
Diabetes			Back Pain		
Kidney Disease			Pain during Urination		
Heart Disease			Change in bowel habits		
High Blood Pressure			Increased thirst		
Arthritis			Persistent Sores/Lumps		
Mental Illness			Infectious Diseases		
Epilepsy/Convulsion			Cancer		
Swelling in the Extremities			Any other physical disability		
Migraine Headaches			Change in energy level		
Fainting or Dizziness			Frequent cough		

TUBERCULOSIS QUESTIONNAIRE

Please indicate if you are suffering from or have a history of the following conditions:

Condition	Yes	No	Condition	Yes	No
Persistent Cough for 3 weeks			Unexplained weight loss		
Blood in sputum			Loss of appetite		
Shortness of breath			Hoarseness		
Night sweats			Fatigue		
Chest pain			Fever		

Do you smoke? ( )Yes ( )No If yes, how much?
_____

Do you drink alcoholic beverages? ( )Yes ( )No If yes, how much?
_____

Do you take depressants, stimulants, narcotic drugs that alter your behavior? ( )Yes ( )No

Do you take prescription medications? ( )Yes ( )No If yes, what are you allergic to?
_____

Name of your physician: _____
Address: _____

I have read the above and declare that I have had no injury, illness or ailment other than as specifically identified. I certify that I am not habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter my behavior.

Employee Signature: _____ Date: _____

RN Name: _____ RN License: _____ RN Signature: _____