# COMPREHENSIVE PATIENT SELF-ASSESSMENT TOOL



**Note to Our Patient Partners: Because YOU are the one who knows yourself best, we want you to be informed, involved participants in your care**. Studies show that people who are actively involved in making decisions about their care are likely to have the best results. In all aspects of your care, remember the following ***Speak Up*** steps, from the Joint Commission on Accreditation of Hospital Organizations (JCAHO)*:

- **S**peak up if you have questions or concerns. If you don't understand, ask again. It's your body and you have a right to know.
- **P**ay attention to the care you are receiving. Make sure you're getting the right treatments and medications by the right health care professionals. Don't assume anything.
- **E**ducate yourself about your diagnosis, your testing procedures, and your treatment plan.
- **A**sk a trusted family member or friend to be your advocate.
- **K**now what medications you take and why you take them. Medication errors are the most common health care errors.
- **U**se hospitals, clinics, surgery centers, or other types of health care organization that have undergone rigorous on-site evaluations against established state-of-the-art quality and safety standards, such as that provided by JCAHO.
- **P**articipate in all decisions about your treatment. You are the center of the health care team.

**1. Get focused and help us prioritize. Tell us your 3 biggest problems or concens.**

**2. Please list any current medical problems**

**3. List any surgery you have had, including date when surgery was done**

**4. (For women) When was your last menstrual period?**

**5. Do you smoke?** ☐ Yes ☐ Quit Smoking ☐ Never Smoked Packs per day ___
Would you like smoking cessation information? ☐ Yes ☐ No

*Courtesy of Joint Commission on Accreditation of Healthcare Organizations, www.jcaho.org



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**6. Do you drink alcohol?** ☐ Yes ☐ No If yes, how much per week?

**7. List allergies and medications (include over-the-counter and herbal drugs).**

**Allergies:**

| Drug | Dose | Taken how often? | Last dose? | Prescribing doctor? |
|---|---|---|---|---|
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**8. Could any of your symptoms be medication related? Remember SODA:**

- ❑ **S**ide effects?
- ❑ **O**ver dosage?
- ❑ **D**rug Interactions?
- ❑ **A**llergy or **A**dverse reactions?

**9. What screening tests have you had done (eg, colonoscopy, mammography)?**

**10. Put an X in the box, if you have a family history of any of the following:**

- ❑ Cancer
- ❑ Heart disease
- ❑ Diabetes
- ❑ Hypertension
- ❑ Glaucoma
- ❑ Mental health problems
- ❑ Other

**11. Children/ Pregnancies:**

Number of living children you have: ___ Number deceased: ___

For women, number of pregnancies you have had: ___



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**12. Place an X in the appropriate box if you have any of the following:**

| | CURRENT PROBLEM | PAST PROBLEM |
|---|---|---|
| Anxiety, depression, or mental health problems | ☐ | ☐ |
| Insomnia (difficulty sleeping) | ☐ | ☐ |
| Arthritis or joint stiffness/pain | ☐ | ☐ |
| Alcohol or drug dependence problems | ☐ | ☐ |
| Asthma or other breathing problems | ☐ | ☐ |
| Back pain | ☐ | ☐ |
| Anemia or bleeding problems | ☐ | ☐ |
| Cancer (breast, prostate, other) | ☐ | ☐ |
| Chest pain, palpitations, heart disease | ☐ | ☐ |
| Circulation problems/swelling feet or ankles | ☐ | ☐ |
| Exercise intolerance-Shortness of Breath | ☐ | ☐ |
| Weakness or fatigue | ☐ | ☐ |
| Fever/sweating | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Eye problems | ☐ | ☐ |
| Headaches | ☐ | ☐ |
| Ear aches/hearing problems | ☐ | ☐ |
| Gynecological problems or pregnancy | ☐ | ☐ |
| Hypertension | ☐ | ☐ |
| HIV | ☐ | ☐ |
| Infection or communicable disease exposure | ☐ | ☐ |
| Medication management problems | ☐ | ☐ |
| Skin problems (rashes, lumps, moles, other) | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ |
| Kidney disease or urinary elimination problems | ☐ | ☐ |
| Bowel elimination problems | ☐ | ☐ |
| Weight loss/gain or nutrition problems | ☐ | ☐ |
| Indigestion/acid reflux | ☐ | ☐ |
| Wound healing problems | ☐ | ☐ |
| Any other problems affecting your care? | ☐ | ☐ |

**Please put today's date here:**

1. Have you understood, and signed HIPAA-required patient privacy form(s)? ☐ Yes ☐ No

2. Please print patients name here; _____

3. Signature of person completing this form: _____

4. If you aren't the patient, what is your relationship to the patient? _____

5. Do you have any other questions? ☐ Yes ☐ No



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