

COMPREHENSIVE PATIENT SELF-ASSESSMENT TOOL

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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 concerns.

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 ____

If you smoke, we strongly recommend that you stop. Please ask for our information on smoking cessation. You CAN do it, with help!

*Courtesy of Joint Commission on Accreditation of Healthcare Organizations, <http://www.jointcommission.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?

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

Today's date: _____

1. Have you understood, and signed HIPAA-required privacy form(s)? Yes No
2. Please print patient's 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
6. If appropriate, don't forget to ask about successful weight management, smoking cessation, and substance (alcohol, drug) abuse programs. **You CAN do it with help.**