



Comprehensive Health Information Data Sheet

Rationale

The purpose of this tool is to provide a single resource for a quick summary of the key elements of the patient's medical, surgical and social history. This tool will also provide a reminder to order preventative health screens

- The medical record should provide a record of comprehensive care and serve as evidence of collaboration between the provider and the patient in learning about the patient's illnesses, treatment options, and services rendered.
- This form should be updated in conjunction with any other update of the patient's medical record.
- This form should be placed in a prominent, easily visible part of the patient's chart to be referenced as needed with each encounter.

Rationales and the tools are not legal advice and are not meant to substitute for medical judgment. You may have other tools, systems or protocols in your practice which may make this tool, or a part of it, unnecessary. Further, the tool, or parts of it, may not be applicable to your specialty or practice. You should use or adapt the tools only if appropriate for your practice. You should always consult your own legal counsel for current legal advice as laws and regulations may change.

Comprehensive Health Data Form

Patient: _____ D.O.B. _____

Advance Directives	Date document signed	Copy in Chart	Does not have	Discussed
Living Will				
Durable Power of Attorney for Health Care				

Date	Diagnoses	Date	Surgeries	Date	Drug Allergies/Reactions
					Other Allergies: Latex, Peanuts, Etc.

Health Screen

CBC & Differential							
Chem Profile							
Lipid Profile							
Hemocult							
Rectal							
EKG							
CXR							
Mammogram							
Pap/Pelvic							
Sigmoid/Colonoscopy							
PSA							
Urinalysis							
PPD							
Tine							

Discussed Yes No

Menopause	<input type="checkbox"/>	<input type="checkbox"/>
Estr/Prog	<input type="checkbox"/>	<input type="checkbox"/>
Calcium	<input type="checkbox"/>	<input type="checkbox"/>
Breast Self-exam	<input type="checkbox"/>	<input type="checkbox"/>
Testicular Self-exam	<input type="checkbox"/>	<input type="checkbox"/>

Immunizations

Pneumovax				Flu					HEP A				
Prevnar				MMR					HEP B				
DPT/DTAP				TD					MCV4				
OPV/IVP				HIB					Varicella				

	No	Yes, amount	Date	Education/Info/Referral	Date
Tobacco					
Alcohol					
Caffeine					
Exercise					
Seat-belts					

Next of Kin		Phone	
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