Community Health Partners[SM]

PHYSICIAN HOSPITAL ORGANIZATION

Initial General Assessment

1. What is your diagnosis or primary physical condition?

____

2. What other conditions do you have?

____

3. List your prescription medications.

____

4. List any herbs, supplements or over-the-counter medications that you take.

____

5. Do you have any allergies? (List any food, medication or seasonal)

____

____

6, Do you have any special needs?

____

7. Please list recent vaccines:
   - A. Flu Vaccine Date__________________
   - B. Pneumonia Date__________________
   - C. Tetanus Date__________________
   - D. Hepatitis B Date__________________

8. Please list you primary language.____

9. To whom (family/friend) may I speak about your medical conditions other than yourself?

____

10. Do you have a living will? _____Yes No_________

11. Do you feel safe in your home environment? ______Yes No_________

Signature:___________________________________ Date:_____________________

P.O. Box 9529, Naples, FL 34101-9935
Phone: 239-659-7770, Fax: 239-659-7785
Toll Free: 1-888-594-9008

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