CoveCare Center
1808 Route Six, Carmel, NY 10512
www.CoveCareCenter.org

Health Screening Form

Client's Name: (Last)___________________________(First)_____________________ (MI)____

Gender: Male Female Transgender Date of Birth: ____/_____/______

Date of Last Physical Examination: ____/_____/______ Height______ Weight_______

Current Primary Medical Care Provider:

Name ____

Address ____

____

Telephone Number ________________________

If you do not have a primary medical care provider, are you interested in getting help to obtain one? ☐No ☐Yes

Have the following changed in the last year? If Yes in what way has it changed?

Appetite ☐No ☐Yes ____

Weight ☐No ☐Yes ____

Sleeping Habits ☐No ☐Yes ____

Energy Level ☐No ☐Yes ____

Please indicate if you do the following. If yes how often?

Exercise ☐No ☐Yes ____

Drink Water ☐No ☐Yes ____

Drink Coffee/ Tea ☐No ☐Yes ____

Drink Energy Drinks ☐No ☐Yes ____

Drink Alcohol (including beer) ☐No ☐Yes ____

Use Drugs (including marijuana) ☐No ☐Yes ____

Smoke Cigarettes ☐No ☐Yes ____

Other Nicotine Products ☐No ☐Yes ____

If you use nicotine products please answer below:

Are there nicotine products in the home with younger children? ☐No ☐Yes

Are you interested in reducing or quitting nicotine? ☐No ☐Yes

Personal Medical History (select all) that apply

High Blood Pressure ☐No ☐Yes

High Cholesterol ☐No ☐Yes

Diabetes ☐No ☐Yes

Heart Attack ☐No ☐Yes

Stroke ☐No ☐Yes

Other Cardiac Condition ☐No ☐Yes

Pulmonary (Emphysema, COPD, Asthma) ☐ No ☐Yes

Kidney Disease ☐No ☐Yes

Liver Disease (Cirrhosis, Hepatitis A/B/C) ☐ No ☐Yes

Endocrine Condition (High or Low Thyroid, Pituitary Disease, Adrenal Disease) ☐No ☐Yes

Overweight ☐No ☐Yes

HIV/AIDS ☐No ☐Yes

Tuberculosis ☐No ☐Yes

Hearing Impairment ☐No ☐Yes

Traumatic Brain Injury ☐No ☐Yes

Cancer ☐No ☐Yes

Mobility Impairment ☐No ☐Yes

Visual Impairment ☐No ☐Yes

Other____

Allergies (drugs, food, environmental): ____

Surgery(s) within the last 6 months-include dates:_______________________________________

Medication/Supplements (Please list all medications/supplements that you are currently taking. Include prescribed/non-prescribed drugs, vitamins and over- the- counter drugs, amount and frequency):

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____

____

Client Signature (If under 18 parent/ guardian must sign) ______________________________Date____/____/____

Clinician Signature ______________________________ Date____/____/____

Date Given To Nurse ____/____/____

Evaluation (To be completed by a physician, nurse practitioner, physician's assistant or registered nurse)

Staff Signature and Title __________ ____Date____/____/____