JOHNSON COUNTY KANSAS
Community Developmental Disabilities Organization

Health Assessment

Name: _____ **Date of Exam:** _____

ID#: _____ **Sex: M F** **Date of Birth:** _____

Physical Assessment

Weight: _____
Height: _____
Temp: _____
Pulse: _____
BP: _____

Nutritional Assessment

Diet: □ **Regular** □ **Restricted:** *Type/Amount*

Type	*Amount*	*Type*	*Amount*
□ NPO:		□ Sodium:	
□ Soft:		□ Calories:	
□ Diabetic:		□ Caffeine:	
□ Cholesterol:		□ Other:	

REVIEW OF SYSTEMS: Please make comments and check all that apply.

Cardiovascular Conditions

Heart tones:
- □ Strong
- □ Regular
- □ Irregular
- □ Murmur
- □ Other: _____

_____

- □ High Cholesterol
- □ High Blood Pressure
- □ Low blood Pressure
- □ Heart Defects
- □ Heart Disease
- □ Other: _____

_____

Genito-urinary Conditions

- □ Bladder
- □ Incontinent
- □ Kidney
- □ Neurogenic Bladder
- □ Prostrate
- □ Renal
- □ UTI (4+/year)
- □ Other: _____

Allergies

- □ Type: _____
- □ Drug: _____
- □ Treatment for allergies:

_____

Gastrointestinal Conditions

- □ Acid Reflux
- □ Chronic Constipation
- □ Chronic Diarrhea
- □ Colitis
- □ G-Tube
- □ Gall Stones
- □ GERD
- □ Hepatitis
- □ Hiatal Hernia
- □ IBS
- □ Liver Difficulties
- □ Malabsorption Diseases
- □ Pancreatitus
- □ Ulcers
- □ Other: _____

_____

Respiratory Conditions

- □ Asthma
- □ Chronic Bronchitis
- □ COPD
- □ Dyspnea
- □ Emphysema
- □ Fibrosis
- □ Pulmonary Edema
- □ Sleep Apnea
- □ Cystic Fibrosis
- □ Other: _____

_____

Psychiatric Conditions

- □ Psychosis
- □ Depression
- □ Bi-Polar
- □ ADD
- □ ADHD
- □ Insomnia
- □ Other: _____

_____

Neurological Conditions

Speech
- □ Verbal
- □ Non-verbal

- □ Seizures
  Type: _____
- □ Dementia: _____
- □ Other: _____

_____

Musculoskeletal Conditions

- □ Arthritis
- □ Joint pain
- □ Muscle pain/cramps
- □ Difficulty walking
- □ Work limitations
  Stand: _____
  Lift: _____
  Other: _____
- □ Other: _____

_____

Name: _____

Reproductive Systems
- □ STD
- □ Perimenopausal
- □ Postmenopausal
- □ Other _____

Endocrine Conditions
- □ Diabetes
- □ Thyroid
- □ Glandular
- □ Hormonal
- □ Other _____

Skin Conditions
- □ Skin Carcinomas
- □ Cysts
- □ Mole Mapping
- □ Skin Tumors
- □ Other _____

Recommendations for Follow-up
- □ OT
- □ PT
- □ Dental
- □ Eyes
- □ Neurologist
- □ Podiatrist
- □ Pap Smear
- □ Psychological
- □ Immunizations _____
- □ Hearing
- □ Mammogram
- □ TB Test
- □ Dermatology
- □ Other: _____
- □ Speech
- □ Dietician
- □ Labs _____
- □ Colonoscopy
- □ Bone Density
- □ Gynecologist
- □ Other: _____

Disability:

Present Diagnosis:

Current Medications:

Medication	Dosage	Purpose

Physician's Signature _____ **Date** _____

Printed Name of Physician _____