# PRELIMINARY HEALTH SCREENING

**Case Name:**

**Name: Last:**       **First:**       **M.I.:**       **Admission Date:**

**Date of Birth:**       **[ ]  Male** **[ ]  Female [ ]  Non-Binary Screen Date:**       **Case #:**

## Section A: Identification (to be completed by local district or shelter staff within 24-hours of admission)

**Emergency Contact (other than head of household)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **Address**: | **Phone**: | **Relationship to Resident**: |
|       |       |       |       |

|  |  |
| --- | --- |
| **Healthcare Provider or Clinic** | **Primary Care Doctor** |
|       |       |

|  |  |
| --- | --- |
| **Name of person providing historical information on this individual, if other than individual:** | **Relationship** |
|       |       |

## Section B: Medical History

**Check each item below as it applies to this individual.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Yes** | **No** | **N/A** | **Current or history** | **If yes, please specify or describe** |
| [ ]  | [ ]  | [ ]  | Less than 18-years old(fill out section C also)  |       |
| [ ]  | [ ]  | [ ]  | Evidence of a contagious condition |       |
| [ ]  | [ ]  | [ ]  | Cancer or immune system diseases  |       |
| [ ]  | [ ]  | [ ]  | Mental health conditions or concerns |       |
| [ ]  | [ ]  | [ ]  | Epilepsy, seizures or fainting spells |       |
| [ ]  | [ ]  | [ ]  | Alcohol or substance abuse |       |
| [ ]  | [ ]  | [ ]  | Surgery or hospitalization within the last six months |       |
| [ ]  | [ ]  | [ ]  | Open or draining wounds |       |
| [ ]  | [ ]  | [ ]  | High blood pressure or diabetes  |       |
| [ ]  | [ ]  | [ ]  | Lung problems such as asthma, chronic bronchitis or COPD |       |
| [ ]  | [ ]  | [ ]  | Receiving treatment for a heart condition  |       |
| [ ]  | [ ]  | [ ]  | Allergies to medication, foods or materials |       |
| [ ]  | [ ]  | [ ]  | Speech, hearing or visual impairment |       |
| [ ]  | [ ]  | [ ]  | Dental problems or concerns |       |
| [ ]  | [ ]  | [ ]  | Is the individual pregnant | Expected delivery date:       |
| [ ]  | [ ]  | [ ]  | If yes, does the individual receive prenatal care |       |
| [ ]  | [ ]  | [ ]  | Currently taking any prescription medications (list) |       |
| [ ]  | [ ]  | [ ]  | Currently taking any controlled substances  |       |
| [ ]  | [ ]  | [ ]  | Receiving treatment for any other medical conditions |       |
| [ ]  | [ ]  | [ ]  | Can the individual ambulate without assistance |       |
| [ ]  | [ ]  | [ ]  | Does the individual appear to be medically healthy |       |

## Section C: Child Immunizations

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Yes** | **No** | **N/A** | **Current or history** | **If yes, please specify or describe** |
| [ ]  | [ ]  | [ ]  | Are child’s immunizations up to date? |       |
| [ ]  | [ ]  | [ ]  | If no, is there an appointment made with the pediatrician to update them? | Appt date:       |

**Does the resident currently need any assistance in finding a doctor or making any medical appointments?**

**Individual’s Signature:**       **Date:**

**[ ]  I am signing on behalf of my child**

**Individual’s Signature:**       **Date:**

**Title:**

In case of transfer: This form is good for 1 year and should transfer with the individual