

Potential Indicators of Medical Issues (Check appropriate Response):

1. Yes No History of diabetes? If yes, when was your last blood sugar taken? _____
What was the result of the blood sugar? _____ (If 400 or greater note reference below)
2. Yes No Any shortness of breath with chest pain and sweating?
3. Yes No Any recent abnormal bleeding, bruising, open wounds, or self-inflicted wounds within the last month? Recent diagnosis of MRSA?
4. Yes No Any new onset of seizures or blackouts?
5. Yes No Any current pain, on a scale of 1 to 10, 1 low and 10 high, that is an 8 or above?
6. Yes No Any recent injuries (falls, loss of consciousness, head injury) within the last two weeks?
7. Yes No Any history of high blood pressure, stroke, or heart disease?
Yes No Any history of a pacemaker?
8. Yes No Have you been hospitalized for a medical condition within the last month?
9. Yes No Do you have any allergies? If so, please list: _____
10. Yes No Do you have any fever or chills (flu-like symptoms) currently?
Yes No Have you had a flu shot this year?
Yes No Have you had a recent covid test? Date and results? _____
11. Yes No Do you need assistance with dressing, bathing, toileting, or walking?
12. Yes No Do you smoke? If so, how much? _____
13. Yes No Have you used any of the following in the past 24 hours?
Alcohol Street drugs Pain medication
14. Yes No Do you use a CPAP machine or oxygen regularly?
15. Yes No Are you, or do you think you might be pregnant?
16. Please list medical conditions/diagnoses:
17. Pharmacy of choice and phone number (if known): _____
18. List of current medications, dosages, and times taken:
19. When was the last time you visited your Primary Care Physician? _____

Some Yes answers may require further medical assessments.