HERMES HEALTHCARE LLC
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ASSESSMENT FORM

Name:		**Date of Birth:**		**Date:**	
Wt:		**Ht:**	**T:**	**BP:**	
P:		**Reg./Irreg. R**		**LMP**	
Checked in By:					
HPIICC: Onset, Location, Duration, Character, Aggravating Factors, Alleviating Factors, Treatment					

	Reviewed	Not Reviewed		Reviewed	Not Reviewed
Medication:	☐	☐	**Allergies:**	☐	☐
Past Hx:	☐	☐	**Immunizations:**	☐	☐
Social Hx:	☐	☐	**Family Hx:**	☐	☐
Changes:			**No Changes Noted:**	☐	

ROS

	YES	NO
Constitutional		
Fever:	☐	☐
Chills:	☐	☐
Fatigue:	☐	☐
Appetite Change:	☐	☐
Weight Change:	☐	☐

Swollen Nodes:	☐	☐
Skin		
Rash:	☐	☐
Itching:	☐	☐
Mole Change:	☐	☐
Lesion:	☐	☐
If yes, **Site:**		
HEENT		
Hearing Loss:	☐	☐
Tinnitus:	☐	☐
Rhinorrhea:	☐	☐
Vision Change:	☐	☐
Headaches:	☐	☐
Congestion:	☐	☐
Sore Throat:	☐	☐
Watery Eyes:	☐	☐
Ear Itch/Pain:	☐	☐
Dizziness:	☐	☐
RESP		
Cough:	☐	☐
SOB:	☐	☐
Chest Pain:	☐	☐
Wheezing:	☐	☐
CV		
Chest Pain:	☐	☐
Palpitations:	☐	☐
Edema:	☐	☐
Orthopnea:	☐	☐
GI		
Nausea:	☐	☐
Vomiting:	☐	☐
Heartburn:	☐	☐

Abdominal Pain:	☐	☐
Diarrhea:	☐	☐
Constipation:	☐	☐
BRB per Rectum:	☐	☐
Hemorrhoids:	☐	☐
Melena:	☐	☐
Bloating:	☐	☐

GU

FEMALE			MALE		
	YES	**NO**		**YES**	**NO**
Dysuria:	☐	☐	**Nocturia:**	☐	☐
Frequency:	☐	☐	**Decreased Force:**	☐	☐
Incontinence:	☐	☐	**Incontinence:**	☐	☐
Breast Masses:	☐	☐	**Penile Discharge:**	☐	☐
Abnl Vag. Bleeding/Discharge:	☐	☐	**Sexual Concerns:**	☐	☐
Frequent UTIs:	☐	☐			
Dyspareunia:	☐	☐			
Stress/Urge Incontinence	☐	☐			
Sexual Concerns:	☐	☐			

Muscoskeletal

Joint Pain or Stiffness:	☐	☐
Limited ROM:	☐	☐
Swelling:	☐	☐
If yes, **Site:**		

Neuro

Seizures:	☐	☐
Tremors:	☐	☐
Syncope:	☐	☐
Near-Syncope:	☐	☐
Numbness/Tingling:	☐	☐
Vertigo:	☐	☐

Unsteady Gait:	☐	☐
Falls:	☐	☐
Psych		
Depressed:	☐	☐
Anxious:	☐	☐
Stressed:	☐	☐
Memory Loss:	☐	☐
Insomnia:	☐	☐
Heme		
Easy Bruising:	☐	☐
Bleeding:	☐	☐
If yes, **Site:**		
Endo		
Goiter:	☐	☐
Increased Thirst:	☐	☐
Increased Urination:	☐	☐
Hot or Cold Intolerance:	☐	☒
Other		

PHYSICAL						
General:	**NL Affect:**	☐	**Neat in Appearance:**	☐	**Abnormal:**	☐
Head:	**Normal Cephalic, atraumatic**			☐	**Abnormal:**	☐
Ears:	**EACs Benign**	☐	**TMs clear w/ good light reflex**	☐	**Abnormal:**	☐
Eyes:	**Sclera white, PERRL, EOM's intact**			☐	**Abnormal:**	☐
Nose:	**Normal Mucous Membranes**			☐	**Abnormal:**	☐
Sinus:	**Non-tender**			☐	**Abnormal:**	☐

Throat:	Pink, moist no exudates					☐	Abnormal:	☐
Neck:	Supple, no nodes					☐	Abnormal:	☐
Thyroid:	Small, non-tender, no nodes					☐	Abnormal:	☐
Lungs:	CTA bilat, no wheezes, rales or rhochi					☐	Abnormal:	☐
CV:	RRR	☐	S1S2	☐	No extra sounds, murmurs	☐	Abnormal:	☐
	No JVD	☐	DP Pulses 2+ & Symmetric		☐	Edema	☐	
Breasts:	nl contours, no masses, no auxiliary LA					☐	Abnormal:	☐
Abd:	Soft, NT, normoactive BS					☐	Abnormal:	☐
	No organomegaly					☐		
	No masses					☐		
GU Female:	Nl ext. genitalia w/o visible legion					☐	Abnormal	☐
Vagina:	well-reguated w/o lesion					☐	Abnormal	☐
	atrophic					☐		
Uterus:	Anteverted					☐	Abnormal	☐
	Retroverted					☐		
	Normal size					☐		
	Absent					☐		
Cervix	nulip.					☐	Abnormal	☐
	multip.					☐		
	No lesion					☐		
	CMT					☐		
	Discharge					☐		
	Absent					☐		
	Pap Taken					☐		
	Cultures Taken					☐		

Adnexa:	**Palpable**	☐	**Abnormal**	☐
	NonPalpable	☐		
	nontender, w/o mass	☐		
GU Male:	**No Penile lesions or discharge**	☐	**Abnormal**	☐
	No Prostate Enlargement	☐		
	No nodules or tenderness	☐		
	No Hernia	☐		
	Scrotum Symmet	☐		
Rectal:	**No sphincter tone, no lesions**	☐	**Abnormal:**	☐
	Hemoccult	☐		
	Neg	☐		
	Pos	☐		
	Deferred:	☐		
Ext:	**No C/C/E:**	☐	**Abnormal:**	☐
	Patellar Reflexes +2:	☐		
Neuro:	**A & O x3:**	☐	**Abnormal**	☐
	CNs II-SII grossly intact:	☐		
	Nl Gait:	☐		
Skin:	**No rashes or suspicious legions:**	☐	**Abnormal**	☐
	Intact:	☐		
	Pink, Warm, Dry:	☐		
Muscoskela -tal:	**Swelling:**	☐	**Abnormal**	☐
	Pain/Tenderness:	☐		
	ROM:	☐		

ASSESSMENT:	
1)	
2)	
3)	
4)	
5)	
6)	

PLAN:					
LAB:					
Blood Sugar:	☐	**CBC:**	☐	**BMP:**	☐
BNP:	☐	**TSH:**	☐	**Lipids:**	☐
Sed Rate:	☐	**CRP:**	☐	**HA1C:**	☐
UA, *culture if indicated*	☐	**Urine Microalbumnin:**	☐	**HA1C:**	☐
Wound Culture:	☐	**Pap:**	☐	**Vag Culture:**	☐
Radiographs:					
Medications:					
Counselling/ Coordination of Care:					

Time: _____ Minutes of a: _____ minute visit.

Re: _____

Referral:	
Follow Up:	

Signature: _____ **Date:** _____