**Medical Assessment**

"Confidential ⎯ this form must always be saved on a secure network   
accessible only by Ryan White funded staff."

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Client name: |  | Client number: |  | DOB: |  | Date: | /    / |

### CM initial:       Initial assessment Reassessment

### Current Psychosocial Acuity *(regional only)*:       Date:   /  /

### Vitals

Phone Assessment Completed

Comments:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Temp:** |  | **Pulse:** |  | | **Respiration:** |  | **B/P:** |  |
| **Height:** |  | **Current weight:** | |  | **BMI:** |  |  |  |

### Labs and Medical provider

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Current: VL** | **Date** |  | **Lowest: VL** | **Date** |  | **Highest: VL** | **Date** |
|  | /    / |  |  | /    / |  |  | /    / |
| Virally suppressed? | Yes  No |  | Virally suppressed? | Yes  No |  | Virally suppressed? | Yes  No |
|  |  |  |  |  |  |  |  |
| **Current: CD4 Count** | **%** |  | **Lowest: CD4 Count** | **%** |  | **Highest: CD4 Count** | **%** |
|  |  |  |  |  |  |  |  |
| **Date** | /    / |  | **Date** | /    / |  | **Date** | /    / |
|  |  |  |  |  |  |  |  |
| **Last medical visit:** | /    / | Provider name: | | | | Provider type: | |
| **Referred to**  **medical provider** | /    / | Provider name: | | | | Provider type: | |
| Comments: | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **HIV status** | | | **HIV risk factors *(check all that apply)*** | | |
| HIV positive *(not AIDS)* | dx date: | /    / | | MSM  Heterosexual  IDU  Perinatal | |
| HIV positive *(AIDS unknown)* | dx date: | /    / | | Receipt of blood or tissue | |
| CDC – defined AIDS | dx date: | /    / | | Hemophilic coagulation disorder | |
| HIV indeterminate (*infants <2*) | dx date: | /    / | | Unknown or not reported/identified | |
|  |  |  | | Other: |  |

### Physical appearance

Phone Assessment Completed

Comments:

|  |  |
| --- | --- |
| Physical deformities |  |
| Posture/mobility |  |
| Skin |  |
| Demeanor |  |
| Speech/hearing |  |
| Personal hygiene |  |
| Comments: | |

### Allergies

|  |  |
| --- | --- |
| Medications:  Yes  No | List: |
| Food:  Yes  No | List: |
| Environmental:  Yes  No | List: |

**Activities of daily living *(self, assistance needed or dependent)***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Activity** | **Self** | **Asst.** | **Dep.** | | **Activity** | **Self** | **Asst.** | **Dep.** |
| Ambulation |  |  |  | | Housekeeping/laundry |  |  |  |
| Transfers/toileting |  |  |  | | Shopping/meal prep/eating |  |  |  |
| Bathing/grooming/dressing |  |  |  | | Driving/getting to appointments |  |  |  |
| Comments: | | | | | | | | |
| Pets/companion animal:  Yes  No | | | | Type: | | | | |

### Current complaints

| **X = Yes** | **Description** | **X = Yes** | **Description** | **X = Yes** | **Description** |
| --- | --- | --- | --- | --- | --- |
|  | Abdominal pain |  | Genital discharge/odor |  | Falls |
|  | Changes in eating habits |  | Fever |  | Changes in strength |
|  | Nausea/vomiting |  | Chills |  | Numbness |
|  | Diarrhea |  | Fatigue |  | Pain |
|  | Unexplained weight loss |  | Night sweats |  | Chest pain |
|  | Difficulty swallowing |  | Swollen lymph glands |  | Cough |
|  | Sores in throat or mouth |  | Seizures/tremors |  | Shortness of breath |
|  | Changes in hearing |  | Dizziness |  | Skin changes/rashes |
|  | Changes in vision |  | Changes in balance |  | Edema |
|  | Genital sores/oral lesions |  | Headaches *(changes in pattern)* |  | Changes in sleep |
|  | Pain/burning with urination |  | Jaundice/Icterus |  | Other: |
|  | Pain with sex |  | Menstrual changes |  |  |
|  | Genital itching |  | Gum bleeding |  |  |
| Comments: | | | | | |

### Medical history

Has client ever been diagnosed with the following infections or conditions? *(C=current; P=past)*  None

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| HIV Related Conditions/ Opportunistic Infections | | Other Comorbidities | | | |
| C  P | ACD *(AIDS Dementia complex)* | Head/Sensory/Neuro | | Endocrine | | |
| C  P | Candidiasis | C  P | Ear, nose and throat | C  P | Diabetes |
| C  P | Cervical cancer | C  P | Hearing problems | C  P | Thyroid problems |
| C  P | Coccidioidomycosis | C  P | Vision problems | Musculoskeletal | |
| C  P | Cryptococcal meningitis | C  P | Epilepsy | C  P | Arthritis |
| C  P | Cryptosporidiosis | C  P | Headaches/migraines | C  P | Osteoporosis |
| C  P | CMV *(Cytomegalovirus)* | C  P | Neurocognitive disorders | C  P | Myopathy |
| C  P | Encephalopathy | Pulmonary | | C  P | Neuropathy |
| C  P | Herpes zoster *(Shingles)* | C  P | Asthma | C  P | Musculoskeletal problems/injuries |
| C  P | Herpes simplex | C  P | COPD | Other | |
| C  P | Histoplasmosis | C  P | Chronic/recurrent sinusitis | C  P | Kidney problems |
| C  P | Isoporiasis | Cardiovascular | | C  P | STI *(sexually transmitted infection)* |
| C  P | Kaposi’s sarcoma | C  P | High blood pressure | C  P | Cancers |
| C  P | Leukeoncephalopathy | C  P | Blood clots | C  P | GI problems |
| C  P | Lymphoma | C  P | Myocardial infarction | C  P | Skin problems |
| C  P | Mycobacterium *(MAC, etc.)* | C  P | Cholesterol — elevated | C  P | Mental Health Diagnosis (*anxiety, depression, PTSD, bipolar, etc.)* |
| C  P | PCP *(Pneumocystis carinii pneumonia)* | C  P | Thrombocytopenia |
| C  P | Pneumonia | C  P | Stroke | C  P | Substance Use Disorders |
| C  P | PML *(Progressive multifocal leukoencephalopathy)* | C  P | Heart Disease | C  P | Sleep problems |
| C  P | Samonella septicemia | C  P | Other: | C  P | Other: |
| C  P | Toxoplasmosis | Liver | |
| C  P | Tuberculosis | C  P | Cirrhosis |
| C  P | Wasting Syndrome | C  P | Hepatitis A, B or C |
| C  P | Other: | C  P | Liver disease/abnormal LFTS |
| Hospitalizations*(for physical or behavioral conditions)*: | | | | | |
| Surgeries: | | | | | |
| Comments*(treatment plans, etc)*: | | | | | |

### Reproductive health

|  |
| --- |
| ***(X-Yes)***  Pregnant  Birth control type:  Breast-feeding  Seeking pregnancy  Erectile dysfunction  Cancer *(cervical, ovarian, prostate, testicular, anal)*  Other: |
| Comments: |

### Immunizations & Screenings

|  |  |
| --- | --- |
| **Current on immunizations: *(X-Yes)***  Flu (*annual*)  Hepatitis A  Hepatitis B  HPV  Meningococcal  MMR  Pneumonia  Shingles  Td/Tdap  Varicella  Mpox  COVID-19 | **Current on screenings: *(X-Yes)***  Breast exam/mammogram  Cholesterol  Colonoscopy *(over 50)*  Gonorrhea  PAP  Prostate  Syphilis  TB  Other |
| Comments: | |

### Tobacco

|  |  |
| --- | --- |
| **Tobacco use:**  Ceremonial or medicinal purposes  Never  Past  Present:  Cigarettes  Chew  Cigars  Vaporizer  Amount:  Interested in cessation |  |
| Comments: | |

**Medications & adherence**

Please ensure all medications, including supplements and vitamins, are listed on medication profile.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Currently prescribed ARVs?  Yes  No  If no, why not?  Not clinically indicated  Does not want to take  Considering  Has not seen Dr. yet  Other | | Currently prescribed other medications?  Yes  No | | |
| Currently taking OTCs, supplements, vitamins or alternative/complementary medicine?  Yes  No  Other | | |
| Currently taking illegal drugs or prescription medications that have not been prescribed?  Yes  No | | |
| Are ARVs taken as prescribed?  Yes  Sometimes  No | | Are other medications taken as prescribed?  Yes  Sometimes  No | | |
| **If yes/sometimes:**  Who is responsible for refilling medications?  Picking up meds:  Giving meds: | | | **If no/sometimes:**  Medications missed:  ARVs  Mental Health  Other  Number of missed doses in past month:  Number of late doses in past month:  Reasons for missed/late doses: | |
| **Are medications: *(X-Yes)***  Borrowed from others  Outdated  Prescribed by multiple providers  Properly stored | | | **Side effects: *(X-Yes)***  Diarrhea  Dizziness  Drowsiness  Headache  Nausea/vomiting  Other: | |
| **Barriers to adherence: *(X-Yes)*** | | | | |
| **Beliefs**  Lack of information  Doubts effectiveness  Religious/spiritual  Other: | **Life situation**  Lack of regular schedule  Work outside home  Caregiving responsibilities  Unstably housed | | **Logistics**  Needs help with ADLs  Difficulty getting refills  Insurance problems  Access to medical supplies *(e.g.syringes)* | **Mental/emotional**  Depression  Unstable mental health  Cognitive changes  Developmental disabilities |
| **Physical**  Loss of appetite  Fatigue  Side effects  Comorbidities | **Regimen**  Complexity  Number of pills  Size of pills  Taste of pills | | **Social**  Lack of support system  Undisclosed HIV status | **Other:** |
| Comments: | | | | |

**Nutrition**

|  |  |
| --- | --- |
| **Visual assessment: *(X-Yes)***  Underweight  Overweight  Obese  Lipodystrophy  Wasting syndrome  Other: | **Barriers: *(X-Yes)***  Access to food  Type of food available  Loss of appetite  Hyperlipidemia  Lack of cooking experience  Recent changes in eating habits  Problems eating *(chewing/swallowing)*  Abdominal issues *(pain, diarrhea, nausea/vomiting)*  Diabetes  HTN  Food allergies/sensitivities  Eating disorders *(anorexia, binging, bulimia)*  Dental issues  Exercise  Other: |
| Comments: | |

**Oral Health**

|  |  |
| --- | --- |
| **Last dental visit:** | **Current hygiene practices:** |
| **Exam: *(X-Yes)***  Missing teeth  Dark, discolored or decayed teeth  Bleeding gums  White hairy growth  Creamy, bump-like patches  Oral lesions  Pain/sensitivity  Difficulty eating or speaking  Dentures and/or need re-alignment  Other: | **Barriers to oral health: *(X-Yes)***  Lack of insurance  Lack of dentist  Lack of transport  Fear of dentist  Other: |
| Comments: | |

**Interventions & Referrals**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Nursing area** | | **Referrals & Interventions Provided** | | **Comments** | | | |
| Medical | | Disease education and information  OTC, vitamins, supplements  Mental Health treatment  Substance use treatment  Naloxone  Aging & Persons with Disabilities  Health insurance assistance  Referral to acupuncture  Referral to PCP  Referral to HIV specialist  Referral to other specialist  Referral to Aiquitline/Quitline/NRT  Other: | |  | | | |
| Adherence | | Pill boxes/reminders    Referral to pharmacist  Other: | |  | | | |
| Nutrition | | Nutritional supplements  Nutritional incentive contract  Referral to food banks/soup kitchens  Referral to dietician  Online resources *(meal ideas)*  Cooking classes  Exercise plan  Dietary changes  Other: | |  | | | |
| Oral Health | | Oral health care education  Dental insurance  Referral to dentist  Other: | |  | | | |
| Other | | Mindfulness/self-help  Other: | |  | | | |
| **Staff name and credentials:** | |  | | **Date:** | /    / |