Oregon Health Authority

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		

X = Yes	Description	X = Yes	Description	X = Yes	Description
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)*	**Current on screenings: *(X-Yes)***
☐ Flu (*annual*)	☐ Breast exam/mammogram
☐ Hepatitis A	☐ Cholesterol
☐ Hepatitis B	☐ Colonoscopy *(over 50)*
☐ HPV	☐ Gonorrhea
☐ Meningococcal	☐ PAP
☐ MMR	☐ Prostate
☐ Pneumonia	☐ Syphilis
☐ Shingles	☐ TB
☐ Td/Tdap	☐ Other
☐ Varicella	
☐ Mpox	
☐ COVID-19	
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)***	**Barriers:** ***(X-Yes)***
☐ Underweight ☐ Overweight ☐ Obese ☐ Lipodystrophy ☐ Wasting syndrome ☐ Other:	☐ 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:** ___/___/________