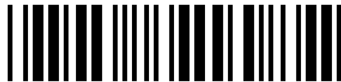
Mount
Sinai
Beth Israel



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AMBULATORY PATIENT SELF ASSESSMENT

Date_____________________________

What is your preferred name? ____

What is your preferred pronoun? ☐ He ☐ She

Please do your best to answer all the questions. If you do not understand a question, your doctor or nurse can explain it. What brings you in today?____

Past Medical History:

Have you ever had any of the following:

MD's Comments:

Anemia	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver Disease or Hepatitis	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Other: ______________________		

Have you ever been hospitalized? ___________ If yes, list when and why: ______________________________

Have you had any surgery? ________________ If yes, list the type of surgery and when: ______________________

Have you ever had a blood transfusion? ☐ Yes ☐ No

Family History:

Do any of your family members have or did they have in the past?

MD's Comments:

Alcoholism	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Thyroid	☐ Yes	☐ No
Glaucoma/Blindness	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Other: ______________________		

List all your medications and doses below (include any vitamins, herbs or supplements):

Name of Medication:	Dose	How often do you take it	**For Physician only:** Reconcile Medication	
1)			☐ Continue	☐ Discontinue
2)			☐ Continue	☐ Discontinue
3)			☐ Continue	☐ Discontinue
4)			☐ Continue	☐ Discontinue
5)			☐ Continue	☐ Discontinue
6)			☐ Continue	☐ Discontinue
7)			☐ Continue	☐ Discontinue
8)			☐ Continue	☐ Discontinue
9)			☐ Continue	☐ Discontinue
10)			☐ Continue	☐ Discontinue

Allergies: Do you have allergies to medications and/or food? ☐ Yes ☐ No If yes, what? ______________________

Social History:

1) Do you smoke? ☐ Current ☐ Former ☐ Never
2) Do you drink alcohol? ☐ Current ☐ Former ☐ Never
3) Do you have any religious or cultural beliefs that your doctor should know about before beginning medical treatment? ☐ Yes ☐ No
4) Do you think of yourself as: ☐ Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Other ______________________
5) Gender Identity: ☐ Male ☐ Female ☐ Transgender Man (assigned female at birth) ☐ Transgender woman (assigned male at birth) ☐ Other ______________________
6) Sex assigned at birth or on your birth certificate: ☐ Male ☐ Female
7) Do you have a Health Care Proxy or Living Will? ☐ Yes ☐ No
8) Has anyone ever hurt you emotionally, physically or sexually? ☐ Yes ☐ No

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Reproductive/Sexual Health:

1) Are you sexually active? ☐ Yes ☐ No
2) What are the genders of your sexual partners? ☐ Men ☐ Women ☐ Both ☐ Other ________________
3) Have you had any sexually transmitted diseases? ☐ Yes ☐ No
4) Would you like to be tested for HIV? ☐ Yes ☐ No ☐ N/A
5) If relevant: Date of your last menstruation or age of menopause ________________ Last Pap Smear ________________
   Last Mammography ________________
6) Do you have any discharge from or lumps in your breast or chest? ☐ Yes ☐ No
7) If relevant: Do you have sores or lumps on your penis or testicles? ☐ Yes ☐ No

Functional Assessment:

8) Do you use any equipment to assist in your daily life? ☐ Yes ☐ No If yes, What? ________________
9) Have you fallen in the past 6 months? ☐ Yes ☐ No
10) Do you have difficulty with balance or walking? ☐ Yes ☐ No

Pain Assessment:

Is pain one of the reasons for your visit here today? ☐ Yes ☐ No If yes, rate your pain from a scale of 1-10 __________

Where is your pain? ________________

Review of Systems:

Constitutional

1) Recent weight change of more than 10 pounds ☐ Yes ☐ No
2) Frequent fevers/night sweats ☐ Yes ☐ No
3) Fatigue/weakness ☐ Yes ☐ No

Eyes/Ears/Nose/Throat

4) Wear glasses/contacts ☐ Yes ☐ No
5) Blurred vision/double vision ☐ Yes ☐ No
6) Difficulty hearing ☐ Yes ☐ No

Respiratory

7) Chronic/frequent coughs/blood in sputum ☐ Yes ☐ No
8) Shortness of breath ☐ Yes ☐ No

Cardiovascular

9) Palpitation/irregular heart beat ☐ Yes ☐ No
10) Chest pain/tightness ☐ Yes ☐ No
11) Swelling of feet/legs ☐ Yes ☐ No

Gastrointestinal

12) Nausea/vomiting ☐ Yes ☐ No
13) Diarrhea or bleeding ☐ Yes ☐ No
14) Constipation or use of laxatives ☐ Yes ☐ No
15) Change in bowel habits ☐ Yes ☐ No

Genitourinary

16) Frequent urination ☐ Yes ☐ No
17) Burning or pain on urination ☐ Yes ☐ No
18) Blood in urine ☐ Yes ☐ No

Endocrine

19) Bothered excessively by hot or cold weather ☐ Yes ☐ No
20) Thirsty most of the time ☐ Yes ☐ No

Hematologic/Lymphatic

21) Bleeding/bruising easily ☐ Yes ☐ No
22) Lumps in neck, armpits, groin ☐ Yes ☐ No

Neurological

23) Frequent or chronic headache ☐ Yes ☐ No
24) Convulsions/seizure ☐ Yes ☐ No
25) History of mini strokes ☐ Yes ☐ No

Psychiatric

26) Depressed or sad ☐ Yes ☐ No
27) Nervous or anxious ☐ Yes ☐ No
28) Attempted suicide or suicide ideations ☐ Yes ☐ No

Musculoskeletal

29) Painful or swollen joints ☐ Yes ☐ No
30) Difficulty or pain with walking ☐ Yes ☐ No

MD's Comments:

Patient Signature ________________
Print Name Signature Date/Time

Provider Signature ________________
Print Name Signature Date/Time