

Chronic Disease Clinic Initial Baseline Medical Data

Check all that apply and complete appropriate clinic HX:

- | | | |
|--|-----------------------------------|------------------------------|
| <input type="checkbox"/> Pulmonary/Asthma/COPD | <input type="checkbox"/> HTN/CV | <input type="checkbox"/> TB |
| <input type="checkbox"/> General Medical | <input type="checkbox"/> Seizures | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Liver Disease/HCV | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Other: _____ | | |

Personal Risk Factors:		Family History:		Surgeries/Hospitalizations:
Y	N	Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smoking: Pack year _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer: types _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>			Substance Abuse: _____
<input type="checkbox"/>	<input type="checkbox"/>			Injection Drug use _____
<input type="checkbox"/>	<input type="checkbox"/>			Multiple sexual partners _____
<input type="checkbox"/>	<input type="checkbox"/>			Unsterile tattooing/body piercing _____

General Description/Chief Complaint:(Attach medication profile or list medications)

Cardiovascular/Hypertension/Diabetes (Date of onset of symptoms: _____)

<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details of boxes checked Y: _____

Inmate Name:	Number:	Institution:	Date:
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Seizures (Date of onset of symptoms: _____)

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Y</td> <td style="width: 50%;">N</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Aura</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Postictal State</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Number of Seizures in past 3 mos. _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Type of Seizures _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Other Neurological Symptoms? (headache, incontinence, paralysis)</td> </tr> </table>	Y	N	<input type="checkbox"/>	<input type="checkbox"/>	Aura		<input type="checkbox"/>	<input type="checkbox"/>	Postictal State		<input type="checkbox"/>	<input type="checkbox"/>	Number of Seizures in past 3 mos. _____		<input type="checkbox"/>	<input type="checkbox"/>	Type of Seizures _____		<input type="checkbox"/>	<input type="checkbox"/>	Other Neurological Symptoms? (headache, incontinence, paralysis)		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Y</td> <td style="width: 50%;">N</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Gum Disease: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Date of Last Seizure _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">LOC</td> </tr> </table>	Y	N	<input type="checkbox"/>	<input type="checkbox"/>	Gum Disease: _____		<input type="checkbox"/>	<input type="checkbox"/>	Date of Last Seizure _____		<input type="checkbox"/>	<input type="checkbox"/>	LOC	
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HIV/HCV Infection (Date of onset of symptoms: _____)

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Asthma/Pulmonary/COPD/Tuberculosis (Date of onset of symptoms: _____)

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Physical Exam

Vital Signs:

Temp:	Blood Pressure:	Pulse:	Resp:	Height:	Weight: (Lbs).	Peak Flow:	Pain Scale:	Functional Assessment:
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HEENT _____

Neck: _____

Heart: _____

Lungs: _____

Abdomen: _____

Extremities: _____

GU/rectal: _____

Other: _____

Labs:

Hgb A1C:	Hct:	ALT:	T. Chlo:	Triglycerides:
CD4 Cell:	Hgb:	BUN:	LDL:	INR:
HIV RNA VL:	AST:	Creatinine:	HDL:	Other:

Assessment: diagnoses

	<u>Degree of Control</u>			
	G	F	P	N/A
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Inmate Name:	Number:	Institution:	Date:
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Education Provided: (describe below)

Disease process/abnormal labs: _____

Medication Mgmt (purposes, side effects): _____

Nutrition: _____

Smoking/Tobacco use: _____

Exercise: _____

Alcohol/substance abuse _____

Other: _____

PLAN:

Medication Changes: _____

Diagnostics:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> EKG | <input type="checkbox"/> CBC | <input type="checkbox"/> Hepatitis Panel A/B/C | <input type="checkbox"/> Liver Enzymes |
| <input type="checkbox"/> Chest x-ray | <input type="checkbox"/> Medication Levels | <input type="checkbox"/> Toxoplasmosis AB | <input type="checkbox"/> LFT |
| <input type="checkbox"/> Lipid Studies | <input type="checkbox"/> HIV Antibody | <input type="checkbox"/> RPR | <input type="checkbox"/> Sputum AFB Smear |
| <input type="checkbox"/> Chemistry | <input type="checkbox"/> CD4 count | <input type="checkbox"/> Pap Smear | <input type="checkbox"/> Sputum AFB Culture |
| <input type="checkbox"/> HgbA1C | <input type="checkbox"/> Viral Load | <input type="checkbox"/> Platelet | |
| <input type="checkbox"/> Urine Micro albumin | <input type="checkbox"/> HCV | <input type="checkbox"/> UA | |

Immunizations:

- Influenza Vaccine Pneumococcal Vaccine

Other Tests: _____

Monitoring:

BP: ___ times per day/week/month Glucose: ___ times per/day/week/month Peak Flow: _____

Other: _____

Referral:

Specialist (indicate specialty and priority level): _____

Other Chronic Care Program? (specify): _____

Inmate Name:	Number:	Institution:	Date:
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