Bloom House Residential Treatment Center

Health Screening Questionnaire

Client Name: Date:

1.) Do you have a primary care provider who manages your medical concerns? ☐ YES ☐ NO
[*Healthcare providers should be identified for collaboration and releases of information*]

Provider name: Provider Contact Info:

Approximately, when is the last time you saw a doctor or other healthcare provider? [Month and year if known]:

What did you see them for?

2.) Do you have any active medical problems or disabilities that you are aware of?
☐ YES ☐ NO
If yes, do any of the medical problems require immediate attention? Briefly explain:

If yes, are you currently using any medications for a physical health issue? ☐ YES ☐ NO
If yes, list all medications and doses:

3.) Are any of these issues directly related to alcohol and/or drug use? ☐ YES ☐ NO
Briefly explain:

4.) Are you pregnant? ☐ YES ☐ NO ☐ UNSURE
If Unsure – have you recently had a pregnancy test? Briefly explain:

If Yes, how many weeks?
Have you established care with an OB/GYN? ☐ YES ☐ NO
OB/GYN Name and contact information:

5.) In the past 30 days, have you been to an urgent care, emergency room, or hospitalized for any medical concerns? ☐ YES ☐ NO
If yes, briefly explain what you were treated for:

6.) I am going to read you a list of physical health issues. Do you currently have, or have you been diagnosed with, any of the following?

☐ Heart problems	☐ Intestinal problems	☐ Hepatitis (A, B or C)	☐ Dental problems
☐ High blood pressure	☐ Neurological issue	☐ Asthma	☐ Tuberculosis (TB)
☐ High cholesterol	☐ Seizures	☐ Lung problems	☐ Diabetes
☐ Blood disorder	☐ Thyroid problems	☐ Muscle/Joint problems	☐ Sleep problems
☐ HIV	☐ Kidney problems	☐ Vision problems	☐ Chronic pain
☐ Stomach problems	☐ Liver problems	☐ Hearing problems	☐ Acute pain
☐ Cancer (specify type):		☐ Allergies (specify):	
☐ Infection(s):		☐ STD(s):	
☐ Other:			

7.) **Interviewer observation:** are any of these medical/physical health issues potentially infectious to other staff or patients? ☐ YES ☐ NO

(Seek medical or nursing consultation if unsure)

If YES, Please describe:

8.) Are you up to date on all your vaccines? (COVID, Tdap, Flu, HepA, HepB, MMR, Tetanus, VAR, other)

☐ YES ☐ NO ☐ UNSURE

If yes to only some, please list those that are up to date:

*Please request that documentation on all vaccines in the last year be sent to the Bloom House via fax (719) 344-4494, or email: bloomreferrals@homewardpikespeak.org

Adult TB Risk Assessment and Screening Form
(For Patient Record)

Name: _____ DOB: _____ Date:_____

TB Risk Assessment	Yes	No
1) Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East? In what country were you born? _____		
2) In the past 5 years, have you lived or traveled in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East for more than one month?		
3) In the last 2 years, have you lived with or spent time with someone who has been sick with TB?		
4) Do you have (or have you had) any of these medical conditions? Diabetes Kidney disease HIV infection Colitis Cancer Stomach or intestine surgery Rheumatoid arthritis		
5) Are you taking any medications that your doctor said could weaken your immune system or increase your risk for infections?		
6) In the past 1 year, have you injected drugs that your doctor did not prescribe?		
7) Have you ever lived or worked in a prison, jail, homeless shelter or long-term care facility? (example: nursing home, substance abuse treatment, rehabilitation facility)		

Symptom Screening – At this time, do you have any of these symptoms?	Yes	No
1) Coughing for more than 2-3 weeks?		
2) Coughing up blood?		
3) Weight loss of more than 10 pounds for no known reason?		
4) Fever of 100°F (or 38°C) for over 2 weeks?		
5) Unusual or heavy sweating at night?		
6) Unusual weakness or extreme fatigue?		