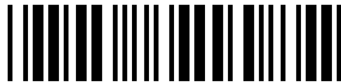

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AMBULATORY PATIENT SELF ASSESSMENT

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

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? ☐