2010 Farmworker Outreach Health Assessment

Adult (19 and up)

Name ____
Age _____ **Date of Birth** ____/____/_____ **Patient ID**____________
DOB: Actual? ____ Estimate? ____ **Sex** ☐ M ☐ F
Have you moved within the last 24 months? ☐ Yes ☐ No
When did you last move to this residence? Date _____/_____/______
Patient Type: ☐ Migrant ☐ H2A ☐ Seasonal ☐ Other
Ethnicity: Hispanic or Latino origin? ☐ Yes ☐ No
Race: ☐ White ☐ Black/Afr. American ☐ American Indian ☐ Asian ☐ Unknown ☐ Other_____________
Primary language spoken (other than English or Spanish): _____________
Need Interpreter? ☐ Yes ☐ No
Insurance Type: ☐ None/Uninsured ☐ Medicaid ☐ Medicare ☐ Health Choice ☐ Private
US Veteran? ☐ Yes ☐ No
Family Size: _______ Income (annual): ____________

Date ____/_____/2010 **OR Worker**______________________
Site No. ____________ **Tel. No.** _________________________
Employer ____
Employer ID_____________ **Service Location** _______________
FW Local Address ____
________________________ **zip**_____________
FW cell phone # ____________________
FW Permanent Address or Emergency Contact #:
____
____
Have 24 hour emergency options been explained? ☐ **Yes** ☐ **No**
DWI laws explained? ☐ **Yes** ☐ **No**
("¿Sabe usted cúales son las consequencias de tomar y manejar?")

General Health Screening

1. BP ____/_____ **Weight**_______ **Height** _________ **BMI** ___________ **Allergies?** __________________________
➡ If BP greater than 120/80 provide health ed ☐ /If BP greater than 140/90 provided health ed and refer ☐ /Referral completed ☐ /Referral declined ☐

2. ¿Tiene algún problema o preocupación sobre su salud? *Do you have any health problems or concerns about your health?* ☐ **Yes** ☐ **No**
Por ejemplo/*For example*: (circle or list:) diabetes, high blood pressure, asthma, HIV, depression, heart problems, cancer, dental, stress, cough/fever, problems w/ vision Other:____

3. ¿Está tomando (o debería estar tomando) medicinas, vitaminas, hierbas, o tratamientos naturales? ☐ **Yes** ☐ **No**
Are you taking any medicines, vitamins, or herbs, or natural treatments? List:______________________

4. ¿Ha recibido las siguientes vacunas?
Have you had the following vaccines?
➡ If vaccines not up to date, referral made? ☐
a) Rubéola (MMR/Rubella) *(Need 1 in lifetime; began 1998 in Mexico)* ☐ **Yes** ☐ **No**
b) Tétano *(Td)* *(<10 yrs)* ☐ **Yes** ☐ **No**

5. ¿Cuando vá en un carro, usa usted el cinturón de seguridad si hay? *If you have a seatbelt, do you wear it?* ☐ **Yes** ☐ **No**
➡ If no seatbelt worn, health ed done? ☐

6. ¿Al trabajar en este último año, ha tenido contacto directo con pesticidas ya sea en el hogar o en el trabajo? ☐ **Yes** ☐ **No** (ie. rociado, brisa, residuo mojado/visible, entrada a un campo con el letrero del periodo restringido) *During this agricultural year have you had direct contact with pesticides at home or work (ie. spray, drift, wet/visible residue, in a field w/restricted entry sign?)*
➡ If yes,**¿Cuando occurio?** When did it occur? ____/_____/____
➡ If yes, refer to protocol? ☐ Pest ed done? ☐

7. ¿Usted fuma? *Do you smoke?* ☐ **Yes** ☐ **No**
➡ If yes, health ed done? ☐

8. ¿Usted toma bedidas alcoholicas, incluyendo cervezas? *Do you drink alcoholic beverages, including beer?* ☐ **Yes** ☐ **No**
If yes: **8b. ¿Cuándo fue la última vez que ingirió más de 5 bebidas alcoholicas al día (4 para mujeres), incluyendo cervezas?**
When was the last time you had more than (4 for women/5 for men) drinks in one day, including beer? ____/____/____ ☐ **Never**
➡ If 1 or more times in last 3 mo, health ed done? ☐

9. ¿Quiere hacerse el exámen de VIH? *Are you interested in being tested for HIV?* ☐ **Yes** ☐ **No**
➡ If yes, provide referral ☐

10. ¿Quiere anticonceptivos/condones? *Would you like contraception/condoms?* ☐ **Yes** ☐ **No**
➡ If applicable, provide health ed, condoms, referral ☐ | If patient is male, skip to #13; If female, move to next section

Women Only for questions #11 and #12:

11. ¿Piensa que es posible que este Ud. embarazada? *Do you think you may be pregnant?* ☐ **Yes** ☐ **No**
➡ If yes, provide test date, referral ☐ declined test ☐

12. ¿Cuando fue su último exámen de papanicolau y que fue el resultado? *When was your last pap test and what was the result?*
Date: ___/___/___ Result:_______________
➡ If more than 12 months ago, provide referral ☐
➡ For women up to age 50, give bottle of vitamins and provide explanation ☐

If choosing depression screen or if concerned that patient may be depressed:

13. Durante las últimas 2 semanas, ¿que tan seguido ha tenido molestias por cualquiera de las siguientes dificultades?
Over the last 2 weeks, how often have you been bothered by any of the following problems?

	No del todo *Not at all*	**Varios dias** *Several days*	**Más de la mitad de los dias** *> half the days*	**Casi todos los dias** *Nearly every day*
a. Poco interés o placer en hacer cosas *Little interest or pleasure in doing things*	0	1	2	3
b. Sintiéndose decaído (a), deprimido (a), o sin esperanzas *Feeling down, depressed or hopeless*	0	1	2	3
SCORING:	0 +	_____ +	______ +	_____ = _____

⬆ score

★ If score greater than 3, administer the full 9-question screen

14. ¿Tiene alguna otra inquietud o preocupación? *Do you have any problems or immediate needs?* ☐ **Yes** ☐ **No**
If yes, please circle: Food Clothing Living Conditions Other _______________________________

Health Education

15. Quisiera darle información sobre algunos temas de salud: *I would like to give you information about some health topics.*
In addition to priority topics: **¿Hay otra información de salud que desea?** *What other health information do you want?*

PRIORITY TOPICS: Health ed provided?				date:
a. clinic services	❒ yes	❒ no	❒ declined	_______________
b. pesticides	❒ yes	❒ no	❒ declined	_______________
c. heat illness	❒ yes	❒ no	❒ declined	_______________
d. DWI	❒ yes	❒ no	❒ declined	_______________
e. STI/HIV	❒ yes	❒ no	❒ declined	_______________

Topic	date:
❒ 911	________________________
❒ Anemia	________________________
❒ Athlete's Foot	________________________
❒ Back Pain	________________________
❒ Car Seat	________________________
❒ Child Care/Parenting	________________________
❒ Child Development	________________________
❒ Cholesterol	________________________
❒ Dental	________________________
❒ Diabetes	________________________
❒ Disaster Preparedness	________________________
❒ Domestic Violence	________________________
❒ Emotional Health	________________________
❒ Family Planning	________________________
❒ First Aid	________________________
❒ Folic Acid	________________________
❒ Green Tobacco Sickness	________________________
❒ HTN/Pre-HTN	________________________
❒ Immunization	________________________
❒ Insect/Snake Bite	________________________
❒ Lead Exposure	________________________
❒ Liv.Cond/Sanitation	________________________
❒ Medication Use	________________________
❒ Nutrition	________________________
❒ Personal Hygiene	________________________
❒ Pre/Post HIV Counseling	________________________
❒ Prenatal	________________________
❒ Poisonous Plants	________________________
❒ Respiratory/Asthma	________________________
❒ Seatbelt	________________________
❒ Skin/Wound Care	________________________
❒ Smoking	________________________
❒ Substance Abuse	________________________
❒ Sun Exposure	________________________
❒ Tuberculosis	________________________
❒ Vision/Eye Care	________________________
❒ Vitamins	________________________
❒ Water Safety	________________________
❒ Other	________________________

Summary

16. What else does this client need help with?

❒ Resources ❒ Transport ❒ Interpretation
❒ Health ed ❒ Med appt ❒ Dent appt

Other: ______________________________________

Notes:

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Notice of Privacy Practices (If applicable - Please have patient initial one)**:**
Se me han explicado los procedimientos de privacidad. ____
I acknowledge that I am aware of the Notice of Privacy Practices. ______________________________________