

Name _____ Age _____ Date of Birth ____/____/____ Patient ID _____ DOB: Actual? ____ Estimate? ____ Sex <input type="checkbox"/> M <input type="checkbox"/> F Have you moved within the last 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No When did you last move to this residence? Date ____/____/____ Patient Type: <input type="checkbox"/> Migrant <input type="checkbox"/> H2A <input type="checkbox"/> Seasonal <input type="checkbox"/> Other Ethnicity: Hispanic or Latino origin? <input type="checkbox"/> Yes <input type="checkbox"/> No Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ Primary language spoken (other than English or Spanish): _____ Need Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance <input type="checkbox"/> None/Uninsured <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Type: <input type="checkbox"/> Health Choice <input type="checkbox"/> Private Family Size: _____ Income (annual): _____	Date ____/____/2010 OR Worker _____ Site No. _____ Tel. No. _____ FW cell phone no. _____ Employer _____ Employer ID _____ Service Location _____ FW Local Address _____ _____ zip _____ FW Permanent Address or Emergency Contact phone no.: _____ _____ Have 24 hour emergency options been explained? <input type="checkbox"/> Yes <input type="checkbox"/> No DWI laws explained? <input type="checkbox"/> Yes <input type="checkbox"/> No ("¿Sabe usted cuáles son las consecuencias de tomar y manejar?")
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**General Health Screening**

1. BP ____/____ Weight _____ Height _____ BMI _____ Allergies? _____ ➔ If BP greater than 120/80 provide health ed <input type="checkbox"/> /If BP greater than 140/90 provided health ed and refer <input type="checkbox"/> /Referral completed <input type="checkbox"/> /Referral declined <input type="checkbox"/>			
2. ¿Tiene algún problema o preocupación sobre su salud? Do you have any health problems or concerns about your health? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;">                             a) Vacunas para niños (childhood vaccines) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                              b) Rubéola (MMR/Rubella) (Need 1 in lifetime; began 1998 in Mexico) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                              c) Tétano (Td) (&lt;10 yrs) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                              d) Hepatitis B (x3) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         </td> <td style="width:50%; border: none;">                             e) ¿Ha tenido viruela locas o varicella? (chicken pox) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                              ➔ e2. If no, had varicella vaccine? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                              f) Menactra ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                              g) Gardasil (for girls only; if boy mark N/A) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                              N/A                         </td> </tr> </table> ➔ If vaccines not up to date, referral made? <input type="checkbox"/>		a) Vacunas para niños (childhood vaccines) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No b) Rubéola (MMR/Rubella) (Need 1 in lifetime; began 1998 in Mexico) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No c) Tétano (Td) (<10 yrs) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No d) Hepatitis B (x3) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	e) ¿Ha tenido viruela locas o varicella? (chicken pox) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No ➔ e2. If no, had varicella vaccine? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No f) Menactra ..... <input type="checkbox"/> Yes <input type="checkbox"/> No g) Gardasil (for girls only; if boy mark N/A) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No N/A
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5. ¿Cuándo vá en un carro, usa usted el cinturón de seguridad si hay? If you have a seatbelt, do you wear it? <input type="checkbox"/> Yes <input type="checkbox"/> No ➔ If no seatbelt worn, health ed done? <input type="checkbox"/>			
6. ¿Al trabajar en este último año, ha tenido contacto directo con pesticidas ya sea en el hogar o en el trabajo? <input type="checkbox"/> Yes <input type="checkbox"/> 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, ¿Cuándo ocurrió? When did it occur? ____/____/____ ➔ If yes, refer to protocol? <input type="checkbox"/> Pest ed done? <input type="checkbox"/>			
7. ¿Usted fuma? Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No ➔ If yes, health ed done? <input type="checkbox"/>			
8. ¿Usted toma bebidas alcoholicas, incluyendo cervezas? Do you drink alcoholic beverages, including beer? <input type="checkbox"/> Yes <input type="checkbox"/> 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? ____/____/____ ➔ If 1 or more times in last 3 mo, health ed done? <input type="checkbox"/>			
9. ¿Quiere hacerse el exámen de VIH? Are you interested in being tested for HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No ➔ If yes, provide referral <input type="checkbox"/>			
10. ¿Quiere anticonceptivos/condones? Would you like contraception/condoms? <input type="checkbox"/> Yes <input type="checkbox"/> No ➔ If applicable, provide health ed, condoms, referral <input type="checkbox"/>			
11. ¿Tiene alguna otra inquietud o preocupación? Do you have any problems or immediate needs? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

PRIORITY TOPICS:	Health ed provided?	date:
a. clinic services	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> declined	_____
b. pesticides	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> declined	_____
c. heat illness	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> declined	_____
d. DWI	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> declined	_____
e. STI/HIV	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> declined	_____

Additional topics on back.

