

NWC/Northern Lake County Mobile Integrated Healthcare Pilot | Client Assessment Form

Date	Visit #: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3 (list #)	Time arrived:	Time departed:
Preferred language:		Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Available? <input type="checkbox"/> Yes <input type="checkbox"/> No
Consecutive interpreting mode: <input type="checkbox"/> Live <input type="checkbox"/> Phone <input type="checkbox"/> Video Name		<input type="checkbox"/> Sign language Resource	
Client legal name:		Client preferred name: <input type="checkbox"/> Same	
Best way to contact them:		E-mail:	DOB
Visit address:		Source of referral to MIH <input type="checkbox"/> EMS ePCR response reports <input type="checkbox"/> Secure online referral form <input type="checkbox"/> Phone call to MIH call center <input type="checkbox"/> Persons/families seeking assistance <input type="checkbox"/> Law enforcement <input type="checkbox"/> PCP <input type="checkbox"/> Community partner	
Type of dwelling: <input type="checkbox"/> Residential property Private home/apartment/condo <input type="checkbox"/> Assisted living establishment <input type="checkbox"/> Long-term care facility <input type="checkbox"/> Children's home <input type="checkbox"/> Homeless <input type="checkbox"/> Shelter/communal living/refuge (safe house) <input type="checkbox"/> Institution/non-residential property <input type="checkbox"/> Religious establishment <input type="checkbox"/> Hospice <input type="checkbox"/> Prison (incarcerated) <input type="checkbox"/> Temporary structure (tent) Other:		Enrollment criteria <input type="checkbox"/> High Utilizer Group (HUG) <input type="checkbox"/> ≥20 EMS calls/90 days (>5/month) <input type="checkbox"/> 10 – 19 EMS calls/90 days <input type="checkbox"/> < 10 calls/90 days with recent change in coping <input type="checkbox"/> Targeted Managed Population <input type="checkbox"/> Early readmission risk (CMS HRRP program) <input type="checkbox"/> Acute myocardial infarction (AMI) <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) <input type="checkbox"/> Heart failure (HF) <input type="checkbox"/> Pneumonia <input type="checkbox"/> Coronary artery bypass graft (CABG) surgery <input type="checkbox"/> Elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA) Additional high readmission risks <input type="checkbox"/> Abuse/neglect; risk of self-harm/suicide risk <input type="checkbox"/> Behavioral health/mental illness, SUD <input type="checkbox"/> Chronic conditions with technology-dependent care <input type="checkbox"/> Diabetes (glycemic control/complications) <input type="checkbox"/> Frail elderly/impaired ADLs; fall risk <input type="checkbox"/> High-risk OB <input type="checkbox"/> Hypertension <input type="checkbox"/> Mobility/transportation impairments/challenges <input type="checkbox"/> Neurodivergent; cognitive delays/impairments <input type="checkbox"/> Nutrition challenges <input type="checkbox"/> Stroke/TIA	
Historian <input type="checkbox"/> Client <input type="checkbox"/> Family member <input type="checkbox"/> Caregiver <input type="checkbox"/> Surrogate/Legal decision-maker Name if different from client: Contact information:			
Legal/decisional capacity <input type="checkbox"/> Legal and mental capacity/Independent/autonomous <input type="checkbox"/> Dependent minor/consent by legal decision-maker <input type="checkbox"/> Emancipated minor <input type="checkbox"/> Minor -Temporary protective custody <input type="checkbox"/> Lacks capacity: Rx per emergency doctrine <input type="checkbox"/> Lacks capacity; Adult Protective Services Act. <input type="checkbox"/> Lacks capacity; Consent by Surrogate <input type="checkbox"/> Consent by Durable Power of Attorney <input type="checkbox"/> Legal conservatorship due to Hx of lethal violence			
Military service status <input type="checkbox"/> NA <input type="checkbox"/> Veteran <input type="checkbox"/> Active duty <input type="checkbox"/> Reserve <input type="checkbox"/> National guard		Height	Weight
Sexual orientation and gender identity (SO/GI) data *Sex assigned at birth <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X <input type="checkbox"/> Decline to answer *Gender identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male/FTM (female-to-male) <input type="checkbox"/> Transgender Female/MTF (male-to-female) <input type="checkbox"/> Genderqueer (non-binary) <input type="checkbox"/> Additional category (specify)			
*Preferred pronouns: <input type="checkbox"/> Decline to answer <input type="checkbox"/> He/him/his <input type="checkbox"/> She/her/hers <input type="checkbox"/> They/them/their <input type="checkbox"/> Use all pronouns <input type="checkbox"/> Try to avoid pronouns <input type="checkbox"/> Unsure of pronouns <input type="checkbox"/> Use other pronouns:			
Race/Cultural heritage/ethnicity: Select all that apply <input type="checkbox"/> Decline to Answer <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian: Original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam <input type="checkbox"/> Hispanic/Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race <input type="checkbox"/> Native Hawaiian or Other Pacific Islander: original peoples of Hawaii, Guam, Samoa, or other Pacific Islands			

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Past Medical History - Complete separate forms below for past known illnesses/conditions & medications

Allergies: Medications NKA Denies allergies
List:

Allergies: Food/environmental/insect stings NKA Denies allergies
List:

Social History	Yes	No	Note nature/amount/frequency; intervention(s)
Exposure to violence/ abuse/ neglect/trafficking			
Alcohol use disorder			<input type="checkbox"/> Need for detoxification
Housing stability			<input type="checkbox"/> Homeless
Social isolation			
Stress			
Substance use disorder			
Tobacco use (vaping)			(# of pack years and previous and current attempts to stop – stage of contemplation)
Other addictions/compulsive behaviors?			
Vaccination History	Yes	No	Recommended dose / schedule
COVID-19			1 or more doses of updated (2023-2024 formula) vaccine
Influenza inactivated (IIV4) or Influenza recombinant (RIV4)			Age ≥19 years: 1 dose any influenza vaccine appropriate for age and health status annually. Age ≥ 65 years: Any quadrivalent high-dose inactivated influenza vaccine (HDIIIV4), quadrivalent recombinant influenza vaccine (RIV4), or quadrivalent adjuvanted inactivated flu vaccine (aIIIV4). If these are unavailable, any other age-approp flu vaccine should be used.
Respiratory Syncytial Virus			Seasonal administration during pregnancy; >60 years
Tetanus, diphtheria, pertussis (Tdap or Td)			1 dose Tdap, then Td or Tdap booster q. 10 yrs 1 dose Tdap ea pregnancy at 27-36 wks 1 dose Td/Tdap for wound mgt
Measles, mumps, rubella (MMR)			No evidence of immunity: 1 or 2 doses depending on indication See notes
Varicella (VAR)			2 doses
Human papillomavirus (HPV) Gardasil 9®			All persons up through age 26 yrs: 2- or 3-dose series depending on age at initial vaccination or condition
Hepatitis A			2, 3, or 4 doses depending on vaccine Any person who is not fully vaccinated and requests vaccination (identification of risk factor not required):
Hepatitis B			Age 19 - 59 yrs: complete a 2- 3- or 4-dose series depending on vaccine or condition:
Haemophilus influenzae type b vaccination (Hib) ActHIB®; Hiberix®; PedvaxHIB®			1 or 3 doses depending on indication Special situations: Anatomical or functional asplenia (including sickle cell disease) or Hematopoietic stem cell transplant (HSCT)
Meningococcal A, C, W, Y (MenACWY)			1 or 2 doses depending on indication, see notes for recommendations First-year college students who live in residential housing (if not previously vaccinated at age ≥16 yrs) or military recruits: 1 dose MenACWY (Menveo or MenQuadfi)
Meningococcal B (MenB)			2 or 3 doses depending on vaccine and indication, see CDC notes for booster recommendation
Mpox vaccine			Any person at risk for Mpox infection: 2-dose series, 28 days apart. Risk factors: persons who are gay, bisexual, transgender or nonbinary meeting listed criteria in the past 6 months
Pneumococcal (PCV15, PCV20, PPSV23)			Age ≥65 years who have Not previously received a dose of PCV13, PCV15, or PCV20 or whose previous vaccination history is unknown
Poliovirus (IPV)			Adults known or suspected to be unvaccinated or incompletely vaccinated: require remaining 1, 2, or 3 IPV doses to complete a 3-dose primary series or trivalent oral poliovirus vaccine (tOPV) in any combination.
Zoster recombinant (RZV)			2 doses for immunocompromising conditions (see notes)

MEDICATION RECONCILIATION		Yes	No	List all substances in Medication Reconciliation section of HealthCalls					
Meds presented match known current prescription lists				<input type="checkbox"/> Unknown					
Taking meds not listed on plan?				<input type="checkbox"/> Unknown					
Adhering to med plan?				Explain					
Can fill pill sorters accurately				Explain					
Personal habits		Yes	No	Barriers to compliance/Comments					
Adhering to healthy diet				Explain:					
Adhering to exercise regimen				Explain:					
Sleep patterns				<input type="checkbox"/> 6-8 hrs/night <input type="checkbox"/> <6 hrs <input type="checkbox"/> >8 hrs <input type="checkbox"/> Insomnia <input type="checkbox"/> Sleeping aid used Change – describe:					
In past 4 weeks, how often has pain , your physical health or emotional state interfered with your normal work and social activities like visiting friends, going out for meals, shopping, and entertainment?				<input type="checkbox"/> All of the time /extremely <input type="checkbox"/> Most of the time/ Quite a bit <input type="checkbox"/> Some of the time/moderately		<input type="checkbox"/> A little of the time <input type="checkbox"/> None of the time			
Compared to usual or known health status - how is the following rated now?									
Physical health				<input type="checkbox"/> Much better <input type="checkbox"/> Better <input type="checkbox"/> About the same <input type="checkbox"/> Somewhat worse <input type="checkbox"/> Much worse					
Exercise tolerance				<input type="checkbox"/> Much better <input type="checkbox"/> Better <input type="checkbox"/> About the same <input type="checkbox"/> Somewhat worse <input type="checkbox"/> Much worse					
ADLs (functional independence)				<input type="checkbox"/> Much better <input type="checkbox"/> Better <input type="checkbox"/> About the same <input type="checkbox"/> Somewhat worse <input type="checkbox"/> Much worse					
Emotional wellness				<input type="checkbox"/> Much better <input type="checkbox"/> Better <input type="checkbox"/> About the same <input type="checkbox"/> Somewhat worse <input type="checkbox"/> Much worse					
Intellectual wellness: memory; thinking; executive functioning				<input type="checkbox"/> Much better <input type="checkbox"/> Better <input type="checkbox"/> About the same <input type="checkbox"/> Somewhat worse <input type="checkbox"/> Much worse					
Spiritual wellness				<input type="checkbox"/> Much better <input type="checkbox"/> Better <input type="checkbox"/> About the same <input type="checkbox"/> Somewhat worse <input type="checkbox"/> Much worse					
Sleep patterns				<input type="checkbox"/> Much better <input type="checkbox"/> Better <input type="checkbox"/> About the same <input type="checkbox"/> Somewhat worse <input type="checkbox"/> Much worse					
Physical Exam as applicable									
Time	BP	MAP	HR	RR	Temp	SpO ₂	EtCO ₂	Waveform	
	Glucose:	ECG rhythm:		12 L ECG interpretation <input type="checkbox"/> Normal Abnormal (list findings):					
Notes for abnormal findings	<input type="checkbox"/> PMH unknown <input type="checkbox"/> Consistent w/ baseline <input type="checkbox"/> New change								
Mental status (see also intellectual wellness)				Pain assessment (0-10)			Pain interventions being used		
Affect/ facial expression <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Behavior <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Cognition <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Insight: Degree to which client understands how their illness or condition impacts their life, relationship with others, and their willingness to change. <input type="checkbox"/> Unusual/bizarre beliefs/perceptions (delusions, hallucinations) Oriented to <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time <input type="checkbox"/> Situation Response to commands <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> No response <input type="checkbox"/> Slowed processing <input type="checkbox"/> Confused <input type="checkbox"/> Agitated/violent				<input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Acute on chronic Rating today: _____ Location/radiation: Provocation/duration/character:			<input type="checkbox"/> Acupuncture <input type="checkbox"/> Cold/ice <input type="checkbox"/> Marijuana/CBDs <input type="checkbox"/> Meditation/visual imagery <input type="checkbox"/> NSAIDs; Tylenol <input type="checkbox"/> Opioids <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Antidepressants <input type="checkbox"/> Anti-seizure meds <input type="checkbox"/> Steroids/antiinflammatories <input type="checkbox"/> TENS unit		
Eye opening <input type="checkbox"/> 4 Spontaneous <input type="checkbox"/> 3 To sound <input type="checkbox"/> 2 To pressure <input type="checkbox"/> 1 None <input type="checkbox"/> NT		Best verbal <input type="checkbox"/> 5 Conversant <input type="checkbox"/> 4 Confused <input type="checkbox"/> 3 Words <input type="checkbox"/> 2 Sounds <input type="checkbox"/> 1 None <input type="checkbox"/> NT		Best Motor <input type="checkbox"/> 6 Obeys <input type="checkbox"/> 5 Localizes <input type="checkbox"/> 4 Normal flexion <input type="checkbox"/> 3 Abn flexion <input type="checkbox"/> 2 Extension <input type="checkbox"/> 1 None <input type="checkbox"/> NT		Speech pattern <input type="checkbox"/> Normal for pt <input type="checkbox"/> Abnormal Articulation <input type="checkbox"/> Normal for pt <input type="checkbox"/> Abnormal Content <input type="checkbox"/> Normal for pt <input type="checkbox"/> Abnormal			
Note all abnormal findings/indicate if known new onset or historical pattern:									

HEENT <input type="checkbox"/> The head is normocephalic and atraumatic without tenderness, visible or palpable masses, depressions, or scarring. <input type="checkbox"/> Cranial nerves II-XII intact <input type="checkbox"/> Facial droop		R	L
Eyes	<input type="checkbox"/> Unremarkable eyebrows, lids, lashes, tear film <input type="checkbox"/> Conjunctiva without pallor, redness, or lesions Sclera without icterus, defects, hemorrhage <input type="checkbox"/> Cornea and anterior chambers clear and without hyphema or defects <input type="checkbox"/> Abnormal findings:		
Pupils PERRLA	<input type="checkbox"/> R L	Vision: <input type="checkbox"/> Blurred <input type="checkbox"/> Diplopia (vertical or horizontal) <input type="checkbox"/> Can read <input type="checkbox"/> Count fingers <input type="checkbox"/> Detect motion <input type="checkbox"/> No Light Perception (blind)	
Dilated		<input type="checkbox"/> Visual fields intact & symmetrical to confrontation. <input type="checkbox"/> Loss of visual field –	
Constricted		Explain:	
Reactive		<input type="checkbox"/> Photopsia (sparks), floaters <input type="checkbox"/> Photophobia	
Non-reactive		<input type="checkbox"/> EOMs intact <input type="checkbox"/> Horizontal or vertical gaze impairment or fixed deviation:	
Ears	<input type="checkbox"/> The pinna, tragus, and ear canal are non-tender and without swelling. The ear canal is visibly clear without discharge. Hearing is intact with good acuity to whispered voice. <input type="checkbox"/> Abnormal findings:		
Nose	<input type="checkbox"/> External nose is symmetrical with no discoloration, swelling or deformity <input type="checkbox"/> Nasal mucosa is pinkish red with no discharge/bleeding, swelling, or FB <input type="checkbox"/> Abnormal findings:		
Mouth	<input type="checkbox"/> Moist oral cavity. Pink mucosa with no discoloration, lesions, bleeding, or swelling. Tonsils are visible but not enlarged. Uvula/tongue in midline. <input type="checkbox"/> No loose, missing, chipped or broken teeth. Gums are pink with no swelling, bleeding, or pain. <input type="checkbox"/> Dentures present <input type="checkbox"/> Oral hygiene OK <input type="checkbox"/> Detectable odors on breath: <input type="checkbox"/> Abnormal findings:		
Neck: <input type="checkbox"/> Supple <input type="checkbox"/> Stiff	Neck veins <input type="checkbox"/> Flat <input type="checkbox"/> JVD <input type="checkbox"/> Carotid bruit <input type="checkbox"/> Lymphadenopathy		
Thorax and lungs	<input type="checkbox"/> Normal chest shape, with no signs of trauma, asymmetry, or visible deformities (barrel chest, kyphosis, or scoliosis). No retractions or tracheal tugging when breathing. Quiet, unlabored respirations with no use of accessory, neck, shoulder, or abdominal muscles. Respiratory rhythm, depth, and effort are normal <input type="checkbox"/> Nonproductive cough <input type="checkbox"/> Productive cough Sputum <input type="checkbox"/> Clear <input type="checkbox"/> White <input type="checkbox"/> Yellow <input type="checkbox"/> Green <input type="checkbox"/> Frothy <input type="checkbox"/> Pink <input type="checkbox"/> Hemoptysis Volume:		
Abnormal findings: <input type="checkbox"/> Asymmetry <input type="checkbox"/> Orthopnea <input type="checkbox"/> ↑WOB <input type="checkbox"/> Accessory muscle use			
Lung sounds	<input type="checkbox"/> Normal vesicular lung sounds		R
Bronchial breath sounds	<input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Lower <input type="checkbox"/> Insp <input type="checkbox"/> Expiratory		L
Wheezes	<input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Lower <input type="checkbox"/> Insp <input type="checkbox"/> Expiratory		
Crackles	<input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Lower <input type="checkbox"/> Insp <input type="checkbox"/> Expiratory		
Pleural friction rub	<input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Lower <input type="checkbox"/> Insp <input type="checkbox"/> Expiratory		
Stridor	<input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Lower <input type="checkbox"/> Insp <input type="checkbox"/> Expiratory		
Heart	Heart sounds: <input type="checkbox"/> S1 <input type="checkbox"/> S2 <input type="checkbox"/> S3 <input type="checkbox"/> S4 (gallop) <input type="checkbox"/> Distant or muffled <input type="checkbox"/> Pericardial friction rub		
Abdomen Inspection	<input type="checkbox"/> Flat/symmetric, no visible lesions, pulsations, discoloration, ecchymoses, herniation, scars, striae, stoma, or peristalsis noted <input type="checkbox"/> Abnormal findings:		
Auscultation	<input type="checkbox"/> Normal bowel sounds <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperactive		
Palpation	<input type="checkbox"/> Soft, non-tender; no guarding, rigidity, masses to palpation, or rebound tenderness Pain/guarding to palpation <input type="checkbox"/> Upper quadrant <input type="checkbox"/> Lower quadrant Rigidity or rebound <input type="checkbox"/> Upper quadrant <input type="checkbox"/> Lower quadrant		
Subjective	<input type="checkbox"/> Issues with nausea, vomiting, food intolerance, heartburn, ulcers, change in appetite, stool elimination, or weight?		

Assessment of Functional needs:

Y N

Activities of daily living

- Client is dressed appropriately for situation/temperature and clothes are clean
- Client can dress independently or with minimal assistance from resources available
- Client can make meals independently or with minimal assistance from resources available
- Client can eat independently or with minimal assistance from resources available
- Client can independently perform personal hygiene, bathing, toileting, & oral care; no evidence of impaired grooming

Describe impairments/deficits and need for interventions:

Mobility

- Client is able to safely climb stairs to bed or bathroom or use chair lift available
- Client is able to safely sit down and stand up from a chair
- Client has mobility impairment is bedridden or must use a cane, walker, wheelchair, scooter
- Client has fallen in last 6 months
- Client could evacuate quickly or shelter in place in an emergency

Describe impairments/deficits and need for interventions:

Disabilities and accommodations

- Cognitive disability Accommodation: _____
- Visual disability Accommodation: _____
- Hearing/auditory processing disability Accommodation: _____
- Life support system: Client is physically linked or has implanted devices needed to sustain their life.

List:

- Behavioral/emotional disability. Accommodation: _____

Describe:

- Speech/communication disability: Accommodation: _____

Describe:

Present at point of client contact:

- Medical equipment – list: _____
- Service animal – type: _____
- Emotional support animal – type: _____

Elemental needs to be addressed

- Housing/shelter Clothing (size and climate appropriate) Food/water Transportation
- Medical care Dental care Emotional security Financial security (social welfare and employment)
- Legal assistance Personal safety Home health aide Others:

Community resources or care navigation information provided to client/caregiver:

Condition-specific client/caregiver education and understanding

Client/caregiver demonstrated understanding and ability to perform/assist w/ the following care as applicable:

- Breathing treatment (inhaler, nebulizer, oxygen) Incentive spirometer
- BP checks Glucose monitoring/insulin delivery devices
- Drain/dressing/wound care Peak flow monitoring
- Exercises Ice machine use or application of ice/cold
- Medication administration Pain management via non-pharmacologic means
- Additional instruction needed/provided:

Prevention and Education strategies

- Education and understanding re: healthy choices** re diet, social habits, and exercise
- Home safety check;** fall analysis and risk abatement completed
- Smoke alarm installed or arrangements made to install
- CO detector installed or arrangements made to install

Does Client have any unanswered questions about self-care, medications, or follow-up appointments?

- Yes No

Comments:

Narrative:

MIH CP Acuity rating after assessment / related actions

	Emergent (high risk): Patient currently unstable/critical threat level
	Call 911 for EMS response and transport to ED Symptoms of a life-threatening illness/injury/situation with a high probability of mortality if immediate intervention is not taken to prevent further deterioration or mitigate threat.
	Urgent (rising risk): Patient currently stable; Not meeting outcome targets
	Health status has the potential to progress in severity or result in complications w/ a high probability for morbidity if interventions are not begun quickly and sustained. Attempt to contact PCP if known and/or notify community partners for access to needed resources.
	Routine (low risk): Patient currently stable; meeting outcome targets
	Answer questions, provide coaching/further instruction prn; ensure ongoing adherence to care plan

Communication with additional healthcare partners/community resources: – Name if voice contact:

PCP Name (if known):

Contact #:

MIH CP name/signature:

License #:

MIH CP name/signature:

License #:

Notes:

* SOGI information: Healthcare clinicians must ask a client for their gender, sex assigned at birth, and preferred pronouns, but there is no legislation requiring them to disclose this information. The medical record system uses sex assigned at birth to determine lab ranges, for example hormone levels and kidney function. Sex is used to remind a healthcare provider of what health screenings are due (e.g. prostate screening and pap smears). Sex along with height, weight, and age are used to determine doses for medication(s).

Interpretation services resource: <https://www.languageline.com/>

[American Heart Association \(AHA\) Life's Essential 8](#) metric and its association with both life expectancy and health span or life expectancy free of chronic diseases such as cardiovascular disease (CVD), cancer, diabetes, and dementia serves as the basis for our life-style healthy choices education and coaching.

- Not smoking;
- Regular physical activity;
- Healthy weight;
- Healthy diet;
- Healthy sleep (defined as an average of 7-9 hours nightly);
- Blood pressure in a healthy range;
- Blood glucose in a healthy range; and
- Non-HDL cholesterol in a healthy range.

NWC/NLC MIH Past Medical History Inventory

Check all that apply

<p>Neurological</p> <input type="checkbox"/> ALS (Lou Gehrig's dx) <input type="checkbox"/> Aphasia <input type="checkbox"/> AVM/cerebral aneurysm <input type="checkbox"/> Concussion <input type="checkbox"/> Delirium/dementia <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting/syncope <input type="checkbox"/> Headache <input type="checkbox"/> Intracranial bleed <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Numbness/neuropathies <input type="checkbox"/> Parkinson's Dx <input type="checkbox"/> Seizure <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Tremors <input type="checkbox"/> Vertigo <input type="checkbox"/> Other	<p>Cardiovascular</p> <input type="checkbox"/> Atherosclerosis/CAD <input type="checkbox"/> Angina/chest pain <input type="checkbox"/> AMI (heart attack) <input type="checkbox"/> Aortic aneurysm <input type="checkbox"/> Cardiac arrest <input type="checkbox"/> Cardiac stent placed <input type="checkbox"/> Carotid stenosis <input type="checkbox"/> Dysrhythmia <input type="checkbox"/> Heart assist device <input type="checkbox"/> Heart failure <input type="checkbox"/> Hypertension <input type="checkbox"/> ICD implanted <input type="checkbox"/> Pacemaker <input type="checkbox"/> Peripheral vascular dx <input type="checkbox"/> Prosthetic heart valve <input type="checkbox"/> Swelling feet/legs <input type="checkbox"/> Other:	<p>Behavioral/mental health</p> <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Autism spectrum disorder <input type="checkbox"/> Dissociative disorders <input type="checkbox"/> Eating disorders <input type="checkbox"/> Factitious disorders <input type="checkbox"/> Hallucinations <input type="checkbox"/> Homicidal thoughts <input type="checkbox"/> Impulse control disorders <input type="checkbox"/> Mood disorders <input type="checkbox"/> Personality disorders <input type="checkbox"/> Post-traumatic stress <input type="checkbox"/> Schizophrenia/psychosis <input type="checkbox"/> Self-harm behaviors <input type="checkbox"/> Somatoform disorders <input type="checkbox"/> Substance-related disorders <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Suicide attempt(s) <input type="checkbox"/> Other:	<p>Gastrointestinal</p> <input type="checkbox"/> Bowel/colon disease (IBS, Crohn's, Celiac dx, appendicitis, ulcerative colitis, diverticulitis, obstruction) <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gastric ulcer <input type="checkbox"/> GERD <input type="checkbox"/> Upper GI bleed <input type="checkbox"/> Lower GI bleed <input type="checkbox"/> Esophageal disorder <input type="checkbox"/> Incontinence stool <input type="checkbox"/> Liver dx: <input type="checkbox"/> Nausea/vomiting (freq.) <input type="checkbox"/> Gallbladder dx/stones <input type="checkbox"/> Ostomy <input type="checkbox"/> Pancreatic dx: <input type="checkbox"/> Spleen disorder: <input type="checkbox"/> Other:
<p>Pulmonary/Respiratory</p> <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Dyspnea on exertion <input type="checkbox"/> Dyspnea at rest <input type="checkbox"/> Home oxygen <input type="checkbox"/> Past ETI <input type="checkbox"/> Past tracheotomy <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pulmonary HTN <input type="checkbox"/> Sleep disordered breathing <input type="checkbox"/> Other	<p>Blood/hematology/metabolic</p> <input type="checkbox"/> Anemia/blood disorder <input type="checkbox"/> Adrenal gland disorder <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Diabetes-Type: _____ <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Obesity <input type="checkbox"/> Sickle Cell Dx <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Venous thromboembolism <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Other	<p>EENT</p> <input type="checkbox"/> Diplopia <input type="checkbox"/> Visual acuity deficits <input type="checkbox"/> Visual field losses <input type="checkbox"/> Blindness, all causes <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hearing deficits/loss <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Retinal detachment <input type="checkbox"/> Retinopathy <input type="checkbox"/> Tinnitus <input type="checkbox"/> Other	<p>Immunological/inflammatory</p> <input type="checkbox"/> Allergic rhinitis <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Arthritis/rheumatic dx <input type="checkbox"/> Chronic fatigue syndrome <input type="checkbox"/> Eczema (atopic dermatitis) <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Gout <input type="checkbox"/> Lupus <input type="checkbox"/> Psoriasis <input type="checkbox"/> Vasculitis <input type="checkbox"/> Other
<p>Infectious disorders</p> <input type="checkbox"/> COVID-19 <input type="checkbox"/> Flu last 12 mos <input type="checkbox"/> HIV Aids <input type="checkbox"/> Hepatitis-type: _____ <input type="checkbox"/> Lyme's disease <input type="checkbox"/> Meningitis <input type="checkbox"/> MRSA, VRSA. C-diff <input type="checkbox"/> RSV <input type="checkbox"/> Sepsis / Septic shock <input type="checkbox"/> STD- list: <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other:	<p>Genitourinary/reproductive</p> <input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Dialysis <input type="checkbox"/> Incontinence urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Prostate enlargement <input type="checkbox"/> Renal disease <input type="checkbox"/> UTI (frequent) <input type="checkbox"/> Urinary retention <input type="checkbox"/> Need for home catheterization <input type="checkbox"/> Other	<p>Musculoskeletal</p> <input type="checkbox"/> Previous fractures <input type="checkbox"/> Previous dislocations <input type="checkbox"/> Previous strains <input type="checkbox"/> Previous sprains <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Weakness <input type="checkbox"/> Other:	<p>Cancer</p> <input type="checkbox"/> Brain <input type="checkbox"/> Liver <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Bone <input type="checkbox"/> Adrenal gland <input type="checkbox"/> Colorectal <input type="checkbox"/> Blood/leukemia/myeloma <input type="checkbox"/> Head and neck <input type="checkbox"/> Lymphoma <input type="checkbox"/> Eye/ocular <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Kidney/bladder <input type="checkbox"/> Pancreas <input type="checkbox"/> Prostate <input type="checkbox"/> Spine <input type="checkbox"/> Thyroid <input type="checkbox"/> Uterus/ovary/cervix <input type="checkbox"/> Skin <input type="checkbox"/> Soft tissue <input type="checkbox"/> Other: <input type="checkbox"/> Metastasis:
<p>Skin/soft tissue</p> <input type="checkbox"/> Burns (TBSA, depth, etiology) <input type="checkbox"/> Pressure ulcers <input type="checkbox"/> Diabetic foot ulcers <input type="checkbox"/> Wounds: <input type="checkbox"/> Bacteria: cellulitis, impetigo, staph infections <input type="checkbox"/> Viruses: shingles, warts, herpes simplex <input type="checkbox"/> Fungi: athlete's foot and yeast infections <input type="checkbox"/> Parasites: lice, scabies <input type="checkbox"/> Other:	<p>Past surgeries: List</p> <input type="checkbox"/> Amputation <input type="checkbox"/> Bariatric surgery <input type="checkbox"/> Cardiac bypass surgery <input type="checkbox"/> Major joint replacement <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Spine fusion <input type="checkbox"/> Other:		