CORRECTIONAL MANAGED HEALTH CARE
INTAKE HISTORY AND HEALTH SCREENING

I. IDENTIFICATION **DATE:** _____

NAME: _____ **OCCUPATION:** _____ **EDUCATION:** _____

DOB: _____ **COUNTY:** _____ **TEXAS UNIFORM HEALTH STATUS UPDATE RECEIVED: Y___ N___**

PREVIOUS TDCJ #(s): _____ **DOI:** _____

Patient Language:	**Name of interpreter, if required:**

TO BE COMPLETED BY THE INMATE / UAP / NURSE

II. FAMILY HISTORY					
1. Blood disease (sickle cell anemia, hemophilia)	YES	NO	4. Heart Disease / High Blood Pressure	YES	NO
2. Cancer	YES	NO	5. Tuberculosis	YES	NO
3. Diabetes	YES	NO			

III. PERSONAL HISTORY					
1. Asthma/Emphysema	YES	NO	14. High Blood Pressure	YES	NO
2. Back Injury	YES	NO	15. Intravenous Drug Abuse	YES	NO
3. Blood Disease (sickle cell anemia, hemophilia)	YES	NO	16. Smoking	YES	NO
4. Cancer	YES	NO	Packs per day:		
5. Cavities	YES	NO	Years:		
6. Depression	YES	NO	17. Kidney Disease	YES	NO
7. Diabetes	YES	NO	18. Liver Disease	YES	NO
8. Drug/ Food Allergies	YES	NO	19. Inpatient Mental Health Treatment	YES	NO
9. Epilepsy/Seizures	YES	NO	20. Outpatient Mental Health Treatment	YES	NO
10. Glasses/Hearing Aid	YES	NO	21. Thoughts of Suicide	YES	NO
11. Gum disease	YES	NO	22. Self-Injury	YES	NO
12. Head Injury	YES	NO	23. Suicide Attempt	YES	NO
13. Heart Disease/Angina	YES	NO	24. Other:		

IV. OBSTETRICS / GYNECOLOGICAL HX			
1. Date of last menstrual period:		4. Date of last pap smear:	
2. Number of pregnancies/live births:		5. Date of last mammogram:	
3. History of Problem pregnancy:		6. History of birth control methods (IUD, pills, etc.)	

V. INFECTIOUS DISEASE CONSIDERATIONS (Personal History)			**COMMENTS**
1. HIV + / AIDS	YES	NO	
Prior HIV test date?			
2. Unprotected Sex with Multiple Partners?	YES	NO	
3. Homosexual / Bisexual Activities	YES	NO	
4. Sexually Transmitted Infection	YES	NO	
5. Hepatitis, Type	YES	NO	
6. Were you born between1945-1965?	YES	NO	
7. Tuberculosis	YES	NO	
8. INH Prophylaxis	YES	NO	
9. Have you ever had a Transplant?	YES	NO	
9B. Have you ever taken transplant medications or are you taking them now?	YES	NO	
9C. If YES, what?			
10. Have you ever received hemodialysis?	YES	NO	
11. Do you have tattoos or body piercings?	YES	NO	
12. Did you utilize clotting factors prior to 1987?	YES	NO	

13. Have you shared any personal items lately contaminated with blood such as razors, needles, or toothbrushes?									YES	NO
14. Have you received any blood transfusions prior to 1992?									YES	NO
A	If **YES** to any of the above indicate family member or self, give date and treatment received:									
B	History of hospitalization?	YES	NO							
	Please list the date, hospital, condition:									
C	Have you experienced any of these symptoms: cough, weakness, weight loss, fevers, night sweats, loss of appetite or lethargy?								YES	NO
	If YES, when?									
D	**DRUG & ALCOHOL HISTORY**									
	What illegal drugs have you used?									
	What was the mode(s) of use? (Please circle)	Smoking	Injection	Inhaled	Ingested					
	What amount and how often did you use drugs and alcohol?									
	When was the last time you used drugs or alcohol?									
	Substance use disorder treatment								YES	NO

TO BE COMPLETED BY UAP / NURSE

VI. OBSERVATIONS										
A	**APPEARANCE**									
	Hygiene & Appearance	Clean, Neat	YES	NO	Other:					
		Dirty, Sloppy	YES	NO						
		Cuts	YES	NO	Bruises				YES	NO
	Skin	Sore	YES	NO	Sweating				YES	NO
		Rashes	YES	NO	Other:					
	Body & Movement	Deformities	YES	NO	Impaired Motor Activity				YES	NO
		Tremor	YES	NO	Other:					
B	**BEHAVIOR AND MENTAL STATUS**									
	Orientation (ask questions and document response):									
	What is today's date?		What time is it?		What place is this?					
	Speech:	Normal	Loud	Soft	Mumbling	Other:				
	Attitude:	Appropriate	Laughing	Crying	Cursing	Quiet	Other:			
C	**THOUGHT CONTENT (Please circle YES or NO)**									
	Are you having current thoughts about suicide or self-injury?								YES	NO
	Do you see or hear things that others do not see or hear?								YES	NO
	Do you have any special powers or abilities?								YES	NO
	Do you receive personal messages from the TV or radio?								YES	NO
	Do you have any phobias or excessive fears?								YES	NO
D	**ORGAN AND TISSUE DONOR**									
	Do you wish to be an organ/tissue donor?								YES	NO
	If YES, complete the Uniform Donor Card (CMC Policy E-31.2 Att. A)									
E	**CURRENT COMPLAINTS**									
	Do you have any current medical, mental health, or dental complaints?								YES	NO
	If YES, what?									
F	**EDUCATION: ACCESS TO HEALTH CARE SERVICES, CO-PAYMENT, and GRIEVANCE SYSTEM**									
	Offender given the HSA-34 document & informed on how to access health care services, co-payment, and grievance process?								YES	NO

TO BE COMPLETED BY NURSE ONLY

VII. MEDICATIONS		
Are you presently taking or supposed to be taking prescribed medications?	YES	NO
If YES, refer to HSM-13, Intake Medication Form on page 5.		

VIII. IS THE INMATETAKING ANY MEDICATIONS ASSOCIATED WITH HEAT STRESS? (Refer to CMHC Policy D-27.2 and D-27.3)					
1. Anticonvulsants			Desipramine (Norpramin)	YES	NO
Topiramate (Topamax)	YES	NO	Doxepin (Sinequan)	YES	NO
2. Anticholinergics			Imipramine (Tofranil)	YES	NO
Benztropine (Cogentin)	YES	NO	Notriptyline (Pamelor)	YES	NO
Biperiden (Akineton)	YES	NO	Amitryptyline (Elavil)	YES	NO
Hyoscyamine (Levbid)	YES	NO	**6. Antimanic**		
Oxybutynin (Ditropan)	YES	NO	Lithium carbonate (Eskalith)	YES	NO
Trihexyphenidyl (Artane)	YES	NO	**7. Beta Blockers**		
3. Antihistamines			Atenolol (Tenormin)	YES	NO
Cyproheptadine (Periactin)	YES	NO	Metoprolol (Lopressor)	YES	NO
Diphenhydramine (Benadryl)	YES	NO	Propranolol (Inderal)	YES	NO
Hydroxyzine (Atarax)	YES	NO	Carvedilol (Coreg)	YES	NO
Promethazine (Phenergan)	YES	NO	**8. Calcium Channel Blockers**		
4. Antipsychotics			Amlodipine (Norvasc)	YES	NO
ALL	YES	NO	**9. Diuretics**		
5. Antidepressants			Furosemide (Lasix)	YES	NO
Clomipramine (Anafranil)	YES	NO	Hydrochlorothiazide	YES	NO
Have you ever had withdrawal or seizures when you stopped using drugs or alcohol?				YES	NO
If you injected drugs, did you share needles, syringes, or intranasal devices				YES	NO

IX. COMMON COMORBIDITIES THAT MAY AFFECT HEAT TOLERANCE					
1. Cardiovascular Disease	YES	NO	7. Seizure Disorder	YES	NO
2. Cirrhosis of the liver	YES	NO	8. Rheumatic Disease	YES	NO
3. Chronic Obstructive Pulmonary Disease/Asthma	YES	NO	9. Sweat gland dysfunction	YES	NO
4. Cystic Fibrosis	YES	NO	10. Thyroid dysfunction	YES	NO
5. Diabetes	YES	NO	11. Age >65	YES	NO
6. Psychiatric conditions	YES	NO			

X. DEVICES (check all applicable & contact as directed)

	Allowed in General Population (issue pass and/or schedule for routine care if applicable)		**Contact Provider**		**N/A**
	Automatic Implantable Cardioverter-Defibrillator (AICD)		Insulin Pump		
	BIPAP or CPAP		LifeVest (Wearable Automatic Defibrillator)		
	Cardiac Pacemaker		Pain Pump (External) Medication: _____ Replenishment Frequency: _____		
	Helmet for patients with head injuries/seizures				
	Holter Monitor				
	Implantable Cardiac Loop Recorder		Pain Pump (Implanted) Medication: _____ Replenishment Frequency: _____		
	Ostomy (self-care)				
	PICC Line				
	Port-a-Cath		Drain (excluding foley catheter)		
	Saline Lock		External Fixator		
	Suprapubic Catheter (Established)		IV Antibiotics (more than TID)		
	Tracheostomy (Established)		Nephrostomy Tube		
	Contact TDCJ Health Services Liaison (HSL)	**N/A**	Ostomy (New)		
	AV Fistula or Graft		Oxygen		
	IV Antibiotics (up to TID)		Peg Tube (new or continuous feeding)		
	Peg Tube (self-care)		Subclavian		
	Permcath (dialysis catheter)		Suprapubic Catheter (New)		
	TDCJ – HSL Notified	**Time:**	Total Parenteral Nutrition (TPN)		
			Tracheostomy (New)		
			TENS Unit		

Name of Provider Notified	**Time:**	
Provider Orders:		
Orders obtained and read back / verified by: (Name)		

XI. DISPOSITION			
Routine referral to (circle one):	Dental	Medical	Mental Health
Immediate Referral to (circle one):	Dental	Medical	Mental Health
Release to general population	YES	NO	

Inmate's Signature:	**Date:**
Screener's Signature:	**Date:**
Nurse's Signature:	**Date:**

Patient Name: <~PATIENT_NAME~> Date: <~SRV_DATE~> Patient DOB: <~PATIENT_DOB~>
TDCJ#:<~MRN~> Facility: <~FACILITY~>

INTAKE MEDICATION FORM

Allergies:

_____

ANTIBIOTICS	IDDM	PSYCH ANTIMANICS
Sulfamethoxazole/Trimethoprim DS 1 tab PO twice daily x days	Insulin NPH units SQ QAM	Lithium mg PO x daily
	Insulin NPH units SQ QPM	**PSYCH NON-FORM MEDS (30 day max)**
ASTHMA / COPD	Insulin R units SQ QAM	Amitriptyline mg PO QPM
Albuterol INH 2 puffs x daily PRN KOP	Insulin R units SQ QPM	Bupropion (circle – IR / SR / XL)_____mg PO x daily
Fluticasone 220 MCG HFA puff(s) twice daily	Insulin R per sliding scale SQ twice daily†	Buspirone mg PO twice daily
ANTICOAGULANT/PLATELETS	**NIDDM**	Chlorpromazine mg PO QPM
EC ASA 81 mg PO once daily	Glipizide mg PO x daily	Doxepin mg PO QPM
Clopidogrel 75mg PO once daily **prior auth**	Metformin mg PO x daily	Gabapentin mg PO x daily
CAD/CHF	**PAIN MEDICATIONS**	Mirtazapine mg PO QPM
Digoxin mg PO once daily	Tylenol mg PO x daily x days	Nortriptyline mg PO PQM
Isosorbide Mononitrate mg PO once daily	Ibuprofen mg PO x daily x days	Paroxetine mg PO once daily
Nitroglycerin 0.4 mg sublingual as directed	Naproxen mg PO x daily x days	Quetiapine mg QPM
DIURETICS	**PSYCH ANTICHOLINERGIC**	**SEIZURE (or PSYCH ANTIMANIC)**
Furosemide mg PO x daily	Benztropine mg PO QPM	Divalproex EC mg PO twice daily
Hydrochlorothiazide mg PO once daily	Diphenhydramine mg PO x daily	Phenytoin mg PO x daily
GERD	**PSYCH ANTIDEPRESSANTS**	Levetiracetam mg PO x daily
Omeprazole mg PO x daily	Citalopram mg PO once daily	Carbamazepine mg PO x daily
	Duloxetine mg PO once daily	**THYROID**
HYPERLIPIDEMIA	Fluoxetine mg PO once daily	Levothyroxine mcg PO once daily
Atorvastatin_____mg PO once daily	Sertraline mg PO once daily	**TUBERCULOSIS**
Pravastatin_____mg PO once daily	Trazodone mg PO QPM	Pyridoxine HCL 50 mg: 2 tabs (100 mg) 2x per week
	Venlafaxine XR mg PO once daily	Rifapentine 150 mg: 6 tabs (900 mg) weekly
HYPERTENSION	**PSYCH ANTIPSYCHOTIC**	Isoniazid 300mg: 3 tabs (900 mg) 2x per week
Amlodipine mg PO once daily	Aripiprazole mg PO once daily	**UNLISTED MEDS**
Atenolol mg PO once daily	Fluphenazine mg PO QPM	†Provide sliding scale directions below if ordered
Carvedilol mg PO twice daily	Haloperidol mg PO QPM	
Hydralazine mg PO x daily	Perphenazine mg PO QPM	
Lisinopril mg PO once daily	Risperidone mg PO QPM	
Metoprolol mg PO twice daily	Thiothixene mg PO QPM	
Terazosin mg PO QPM	Trifluoperazine mg PO QPM	
	Ziprasidone mg PO twice daily	

HIV ANTIRETROVIRALS		
Abacavir (Ziagen) 300 mg: 2 tabs (600 mg) PO once daily	Elvitegravir/cobicistat/tenofovir/emtricitabine (Genvoya): 1 tab PO once daily **prior auth**	Ritonavir (Norvir) 100 mg: 1 tab (100 mg) PO once daily
Atazanavir (Reyataz) 200 mg: 2 caps (400 mg) PO once daily	Etravirine (Intelence) 100 mg: 2 tabs (200 mg) PO twice daily	Ritonavir (Norvir) 100 mg: 1 tab (100 mg) PO twice daily
Atazanavir (Reyataz) 300 mg: 1 cap (300 mg) PO once daily [with ritonavir 100 mg daily]	Fosamprenavir (Lexiva) 700 mg: 2 tabs (1400mg) PO once daily [with ritonavir 100 or 200 mg daily]	Tenofovir (Viread) 300 mg: 1 tab (300 mg) PO once daily
Bictegravir/emtricitabine/tenofovir (Biktarvy) 50/200/25 mg: 1 tab PO once daily **prior auth**	Lamivudine (Epivir) 300 mg: 1 tab (300 mg) PO once daily	Zidovudine (Retrovir) 300 mg: 1 tab (300 mg) PO twice daily
Darunavir (Prezista) 800 mg: 1 tab (800 mg) PO once daily [with ritonavir 100 mg daily]	Lopinavir/ritonavir (Kaletra) 200/50 mg: 4 tabs (800/200 mg) PO once daily	
Darunavir (Prezista) 600 mg: 1 tab (600 mg) PO twice daily [with ritonavir 100 mg twice daily]		Azithromycin 600mg: 2 tabs (1200 mg) once weekly
Dolutegravir (Tivicay) 50 mg: 1 tab (50 mg) PO once daily	Raltegravir (Isentress) 400 mg: 1 tab (400 mg) PO twice daily	Dapsone 100 mg: 1 tab (100 mg) PO once daily
Efavirenz (Sustiva) 600 mg: 1 tab (600 mg) PO once daily	Rilpivirine (Edurant) 25 mg: 1 tab (25 mg) PO once daily **prior auth**	Sulfamethox/Trimeth DS: 1 DS tab daily

INTAKE MEDICATION FORM

Provider Signature:_____ **Date:**_____

VO:_____ **Date:**_____ **RBVO /TO: Yes or No** **Date:** _____