STATE OF ALASKA **DEPARTMENT OF CORRECTIONS**

Health History

Prisoner Name ____________________ OB# ____________________

HAVE YOU EVER	YES	NO	DO YOU?	YES	NO
Lived with anyone who had TB			Wear glasses or contact lenses		
Coughed up blood			Have vision in both eyes		
Bled excessively after injury			Wear a brace or back support		
Attempted Suicide			Wear dentures or other prosthetic		

HAVE YOU EVER HAD OR HAVE YOU NOW?	YES	NO	DON'T KNOW	HAVE YOU EVER HAD OR HAVE YOU NOW?	YES	NO	DON'T KNOW
Asthma				Night Sweats			
Tuberculosis				Tumors, cysts or growths			
Cancer or Tumor				Cramps in your legs			
Diabetes				Rupture or hernia			
Emphysema				Recent gain or loss of weight			
Ear, nose or throat trouble				Frequent indigestion			
Hearing loss				Stomach trouble or ulcer			
Chronic or frequent colds				Hepatitis or jaundice			
Hay fever				Gall bladder trouble			
Severe tooth or gum trouble				Hemorrhoids or rectal trouble			
Shortness of breath				Head injuries			
High blood pressure				Epilepsy or seizures			
Pain or pressure in heart				Frequent or severe headaches			
Pounding heart				Loss of memory or amnesia			
Arthritis or bursitis				Periods of unconsciousness			
Fractures (broken bones)				Paralysis, numbness, weakness			
Bone, joint, or other deformity				Dizziness, fainting spells			
Painful or trick shoulder				Nervous problem of any type			
Foot trouble				Alcoholism			
Recurrent back trouble				Syphilis, gonorrhea			
Swollen or painful joints				Drug allergies			
Kidney trouble				Lumps, pain, discharge on breast			
Frequent or painful urination				Change in menstrual pattern			
Blood in urine				Pregnancy/abortion/miscarriage			
Recurrent infections				Treated for female disorder			
Rheumatic fever				Thyroid trouble			

YOUR PRESENT DOCTOR'S NAME (address, phone)	Have you ever been a patient or received treatment in a hospital? (surgery/injuries); state where, when, why & address
Have you ever been treated for a mental condition (If yes, state reason and give details)	Have you ever taken narcotics? (If yes, state what kind, when you last took it, and if you are in a treatment program)
Do you have any current health problems?	Have you ever been incarcerated in this jail before? (If so, when?)

How would you describe your health?

	YES	NO	DON'T KNOW
Do you use or have you used IV drugs?			
Have you even had an operation/surgery?			
Are you heterosexual, bisexual, or gay?			
Have you ever had sex with an IV drug user?			

STATE OF ALASKA **DEPARTMENT OF CORRECTIONS**

Prisoner's Name: ______________________ OB#: __________

Blood Pressure:	Pulse Rate:	Pulse Rhythm:	Respir. Rate:	Respir. Rhythm:
Height:	Weight:	Temp.:	Visual Activity:	Ocular Tension:
General Appearance:	☐ Healthy	☐ Unhealthy		

	PARTS OF THE BODY		OBSERVATION
1)	Head, face, scalp		
2)	Skin	(a) lesions, ulcers, jaundice	
		(b) lacerations, tracks	
3)	Eyes	(a) pupils	
		(b) conjunctive, sclera	
4)	Ears	(a) pinnae, canals, drums	
		(b) gross hearing	
5)	Nose		
6)	Mouth	(a) teeth/dentures	
		(b) throat	
7)	Neck	(a) lymph nodes	
		(b) masses	
		(c) thyroid	
8)	Chest Wall		
9)	Breasts		
10)	Lungs		
11)	Heart	(a) rate	
		(b) murmurs	
12)	Abdomen (appearance)		
13)	Liver	(a) size (cm)	
		(b) tenderness	
		(c) edge	
14)	Spleen		
15)	Groin	(a) nodes	
		(b) lesions	
		(c) hernias	
16)	Back	(a) pain	
		(b) range of motion	
17)	Extremities	(a) clubbing	
		(b) tracks	
18)	Flanks		
19)	Joints	(a) deformity	
		(b) range of motion	
20)	Neurological	(a) reflexes	
		(b) gross touch	
		(c) gait	
		(d) oriented	
		(e) speech	
21)	Rectal/Prostate		
22)	MALES: penis, scrotum, testes		
23)	FEMALES:	(a) vulva, vagina	
		(b) cervix	
		(c) uterus, adnexa	
	Laboratory Results	PPD or time	U.A.

Department of Corrections, Form 807.14D
Rev. 09/07

Physical Examination (Continued)

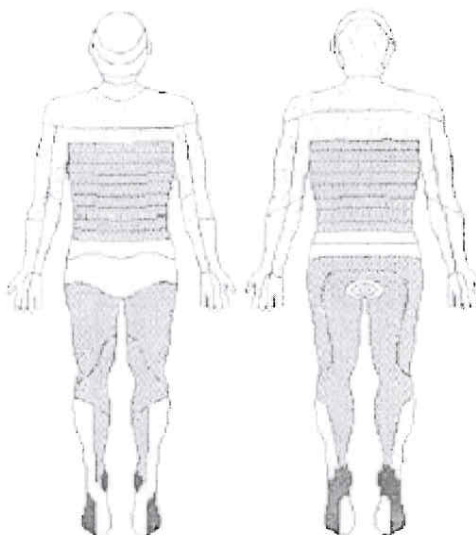
Prisoner's Name ______________________________

OB# ________________

Injuries and Identification Marks on Admission

Mark with a numbered arrow location of the following:

1. Bruise
2. Cut
3. Swelling
4. Sore
5. Amputation
6. Bandage
7. Cast
8. Scar
9. Tattoo
10. Birthmark
11. Sensory Change (describe)



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Signature of Examiner

____
Date