Comprehensive Health Assessment
Practice Checklist

Before the visit:
- Explain the Comprehensive Health Assessment Visit to the patient
- Is the problem list complete?
- Is the medication list complete (Prescription and over-the-counter medicine)?
- Is the family history complete (Medical and surgical)?
- Do we have a list of the patient's other physicians?
- Are most recent laboratory findings, radiographic findings and EKG screenings in the record?
- Did the patient receive a reminder for the visit?

During the visit:
- Have the patient complete a depression screen (Adult and adolescents using PHQ2, PHQ9 or other nationally recognized tool)
- Update patient demographics (Age, gender, and phone number), allergies, patient’s chief complaint and history of present illness.
- Measure BP, weight, height and/or waist measurement
- Complete review of risk factors and mental health status (Behaviors affecting health, medical history of patient and family, patient and family mental health/substance abuse)
- Address communication needs taking into consideration family/social/cultural characteristics
- Update immunization record and order immunizations.
- Update preventive and chronic conditions screenings. (Includes developmental screening using a standardized tool for pediatric patients)
- Provider review and documentation of medical conditions:
  - Diabetes, HTN, CAD/MI, HF, COPD, Asthma, Cancer, IBS
  - Medical condition status (Active/Stable, progressive, resolved)
  - Review and reconcile medications.
- Provider review and documentation of Plan of Care. Address important condition specific gaps in care:
  - Medication and treatment history: poly-pharmacy, multiple providers, reason for hospitalization (if applicable), reason for ER visit (if applicable)
  - Weight loss/gain in last 6 months
  - Appetite change
  - Sleep changes
  - Chronic pain status
- Discuss advance directive. (NA for pediatrics)
- Refer for:
  - Screening tests
  - Nutritional interventions
  - Treatment of depression
  - Self-Management Support (Community referral, Case Management Programs)
  - Tobacco cessation
  - Behavioral Health/Social Worker

This tool is intended for educational purposes only as an example of a checklist. Providers should create their own checklist to meet the needs of their practice. This tool is not intended to replace a provider’s clinical judgment regarding the management of their patients.