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| What is the main reason for your visit today?**Please complete the following information:** |
| Are you having any problems or symptoms today that you would like to discuss?  yes  no If you answered yes, please briefly explain:  |
| Are you allergic to any medicines or foods?  yes  no If you answered yes, please list what medicines or foods you are allergic to and your reaction to each:  |
| Current medications (*Prescription / Over the counter)*:  None  Multivitamins  Calcium  Birth Control \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: |
| Have you had any hospitalizations, major injuries, or surgeries?  yes  no If you answered yes, please briefly explain: |
| Living Conditions:  Alone  With family: # of children in home\_\_\_\_\_\_\_  With Roommate  In group or foster home |
| Marital Status:  Single  Married  Divorced  Widowed |
| Education:  Not a student. Highest education level completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Student: School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_  | Employment:  Not employed Currently employed: Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Please check if you have or have had any of the following:**  **NO CURRENT COMPLAINTS****CONSTITUTIONAL** **HEAD, FACE, NECK CARDIOVASCULAR RESPIRATORY** Fatigue  Headaches  Angina or heart attack Asthma or Wheezing Difficulty sleeping  Reduced facial strength  Chest pain or pressure  Difficulty breathing Fever/chills  Recent hair loss  Fast or irregular heart beat  Cough with mucous production Night sweats  Scalp tenderness  Swelling of feet / ankles  Chronic or frequent coughs Recent weight change  Swollen glands in the neck  Poor circulation  Dry cough  Blood clots  Pain on breathing**EYES**  **CHEST/BREAST**  High blood pressure  Spitting/coughing blood Blurred or double vision Breast dischargeDryness / Redness  Breast lump  **GENITOURINARY MUSULOSKELETAL** Wear glasses or contacts  Breast pain  Burning or painful urination  Back pain Cataracts  Breast implants  Blood or pus in urine  Cold extremities Glaucoma  Incontinence or dribbling  Numbness or tingling  **GASTROINTESTINAL**  Vaginal discharge  Paralysis**EARS/NOSE/MOUTH/THROAT**  Heartburn or indigestion Irregular periods  Joint painEaraches or drainage  Loss of appetite  Painful periods  Joint stiffness or swellingRinging in the ears  Abdominal pain  Prostate problems  Weakness of muscles or jointsHearing loss  Changes in bowel habits  Testicular pain  Walk with assistive deviceSinus infections/problems  Painful bowel movements  Sexual difficulty  Difficulty climbing stairsNosebleeds  Constipation  Genital rash or ulcers Frequent sore throat  Frequent diarrhea  **NEUROLOGICAL / PSYCHIATRIC**Dryness of the mouth  Hemorrhoids/blood in stool **SKIN** Convulsions or seizuresBad breath/bad taste  Nausea or vomiting  Rash or itching TremorsMouth sores/ulcers  Abnormal liver tests/ liver disease  Change in moles Memory loss or confusionVoice changes  Change in skin color Light headed/ DizzinessBleeding gums **ENDOCRINE**  Psoriasis Loss of consciousness Difficulty swallowing  Diabetes  Skin nodules or bumps Stroke Dentures  Thyroid disease  Easy bruising  Depression  Excessive thirst  Sores that won’t heal  Change in tolerance to hot/cold weather |

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| **Please  those that apply to you or your blood relatives.** |
|  | You (Patient) | Father | Mother | Brother | Sister | Grandparent | Child |
| HIV/AIDS |  |  |  |  |  |  |  |
| Alcohol / Drug Addiction |  |  |  |  |  |  |  |
| Alzheimer’s |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |
| Birth Defects |  |  |  |  |  |  |  |
| Bleeding Disorder / Free Bleeder |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |
| BRCA gene mutation |  |  |  |  |  |  |  |
| COPD / Emphysema / Chronic Bronchitis |  |  |  |  |  |  |  |
| Diabetes  |  |  |  |  |  |  |  |
| Epilepsy / Convulsions / Seizures |  |  |  |  |  |  |  |
| Heart Attack / Stroke |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |
| Liver Disease / Hepatitis |  |  |  |  |  |  |  |
| Mental Illness / Depression |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |
| Sickle Cell |  |  |  |  |  |  |  |
| Thyroid Disorder |  |  |  |  |  |  |  |
| Tuberculosis/TB |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |
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| **Nutrition: check foods you eat every day**Milk / Dairy Meats Vegetables Fruits Breads or Grains | **Do you have concerns about your weight?** Yes No | **Exercise**  None  Seldom  Occasional  Frequent |
| **Tobacco Use / Smoke Exposure** Never used  Exposed to smoke Past user: type \_\_\_\_\_\_\_\_\_\_\_\_\_\_Use now: type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (# per day \_\_\_\_\_)  | **Alcohol** None Seldom: type \_\_\_\_\_\_\_\_\_\_\_ Occasional: type \_\_\_\_\_\_\_\_Frequent: type \_\_\_\_\_\_\_\_\_\_ | **Street Drugs**None Seldom: type \_\_\_\_\_\_\_\_\_\_\_Occasional: type \_\_\_\_\_\_\_\_Frequent: type \_\_\_\_\_\_\_\_\_\_ | **Mental Health**: (*in past 90 days)*  No Problem  Mild/Moderate Depression  Severe Depression  Anxiety Thoughts of harming self / others  |
| **Dental Health**Brush daily Floss daily Visit dentist every 6 months | **Water Source:**  Well  Cistern  Bottled  City | **Travel:** No travel outside USA Traveled outside USA: Country/Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_ |
| **Abuse / Neglect / Violence:**   No fear of harm Pressure to have sexDaily needs not met Forced sexual contactFear of verbal/physical abuseSex for money or drugs | **Sexually Active with:**   not sexually activeMales Females  Both Number of partners: in past month \_\_\_\_\_ in past 2 months \_\_\_\_in past 12 months \_\_\_\_\_\_ | **Females only:** Do you examine your breasts every month? Yes NoFirst day of last menstrual period:\_\_\_/\_\_\_/\_\_\_ |
| **Reproductive Life Plan:** Do you have any children?  yes  no Do you want more children?  yes  no If yes, how many more children do you want to have and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What type of birth control are you using to prevent pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  none  |
| **Patient Signature: Healthcare Provider Signature: Date:** |

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| **TO BE COMPLETED BY HEALTHCARE PROVIDER** |
| **FEMALES ONLY** | **MALES ONLY** |
| Age of menarche: # Days between periods: # Days of bleeding:Problems with menses:  yes  noDescribe: | # living children:  |
| Fertility problems:  yes  noDescribe: |
| Hx of testicular biopsy:  yes  noDate / Year: Result: |
| Age at first pregnancy:G Para SAB ETP# living children: |
| PSA testing:  yes  noMost recent date / year:Result: |
| Hx of NTD:  yes  no |
| Age at last pregnancy:Date of last delivery: |
| Hx of abnl PSA:  yes  noDate / Year: Result:  |
| Fertility problems:  yes  noDescribe: |
| Currently using contraception:  yes  noType: | Digital rectal exams:  yes  noMost recent date / year: Result: |
| Interruption in B/C method?  yes  no Describe: |
| Menopausal symptoms:  yes  no Describe: | Hx of abnl digital rectal exam:  yes  noDate / Year:Result: |
| HRT:  yes  noType:  |
| Sigmoidoscopy:  yes  noDate / Year:Result: |
| Age at final menses:  |
| Rubella status:  immune  unknown |
| DES Exposure:  yes  no  unknown  | FOBT:  yes  no Year: Result:  pos  neg |
| Routine Pap Tests:  yes  noMost recent date / Year: Result:  |
| Colonoscopy:  yes  no Year:Result: |
| Hx of abnl pap / HPV:  yes  no Date / Year: Result:  |
| **SEXUAL HISTORY** |
| Hx of colposcopy/biopsy: yes  noDate / Year: Result:  | Sexual partners:  men  women  both |
| # Sexual partners: lifetime\_\_\_\_ last year\_\_\_last 60 days\_\_\_last 30 days\_\_\_ Aware of sexual hx of sexual partner(s)  yes  no  not sure |
| Mother,sister,daughter with breast cancer < age 50?  yes  no |
| Currently breastfeeding: yes  noEver breastfed:  yes  no | Sex with anonymous partners:  yes  no |
| First sexual contact <18 yrs of age:  yes  no |
| Routine Mammograms:  yes  noMost recent date / Year: Result: | Bleeding, spotting, pain with intercourse:  yes  noDescribe: |
| Hx of abnl mammogram / CBE:  yes  noDate / Year: Result:  | Condoms used routinely:  yes  no |
| Hx of STDs:  yes  noHx of > 2 STDs:  yes  noDisease(s): |
| Hx of breast biopsy:  yes  noDate / Year: Result:  |
| FOBT:  yes  no Year: Result:  pos  neg | HIV tested:  yes  no Most recent date: Result:  pos  negUnprotected sex since last test:  yes  no |
| Colonoscopy:  yes  no Year: Result: |
| **Immunization Status:**  Up to date by patient report  Records Requested  See Vaccine Administration Record  Vaccines given today | **Lead Assessment:**  Verbal Risk Assessment: neg  pos N/A Tested Today:  yes  no Referred for testing:  yes  no |
| **Preventive Health Education:** *topics discussed today* Child development Safety  Preconception /Folic Acid  Pelvic / Pap  Immunizations  Mental Health  Prenatal / Genetics  HRT Dental  DV/SA  SBE /Mammogram  STD / HIV/ HCV Hearing/Vision  ATOD / Cessation / SHS  Options Counseling Lead exposure (ACH-25a)  Diabetes  Osteoporosis  Reproductive Life Plan  Diet / Nutrition  CVD  Cancer  Physical activity  Arthritis  STE / PSA  | **Educational Handouts:** FPEM  PTEM  CSEM  Other:  |
| **Minor Family Planning Counseling:** AbstinenceSexual coercionBenefits of parental  involvement in choices |
| **Patient verbalizes understanding of education given**  |

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| **Healthcare Provider Signature: Date:**  |

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| **SUBJECTIVE / PRESENTING PROBLEM:** |
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| **OBJECTIVE: General Multi-System Examination** |
| SYSTEM | NL | ABNORMAL | **hp female picture** | SYSTEM | NL | ABNORMAL |
| Constitutional | General appearance |  |  | Lymphatic | Neck,Axilla,Groin AC |  |  |
| Nutritional status |  |  | Musculoskeletal | Spine |  |  |
| Vital signs |  |  | ROM |  |  |
| HEENT | Head: Fontanels, Scalp |  |  | Symmetry |  |  |
| Eyes: PERRL |  |  | Skin / SQ Tissue | Inspection(rashes) |  |  |
| Conjunctivae, lids |  |  | Palpation (nodules) |  |  |
| Ear: Canals, Drums  |  |  | Neurological | Reflexes  |  |  |
| Hearing |  |  | Sensation |  |  |
| Nose: Mucosa/ Septum |  |  | Psychiatric | Orientation  |  |  |
| Mouth: Lips, Palate  |  |  | Mood / Affect |  |  |
| Teeth, Gums |  |  | **EXPLANATION OF ABNORMAL FINDINGS:** |
| Throat: Tonsils |  |  |  |
| Neck | Overall appearance |  |  |  |
| Thyroid  |  |  |  |
| Respiratory | Respiratory effort |  |  |  |
| Lungs |  |  |  |
| Cardiovascular | Heart |  |  |  |
| Femoral/Pedal pulses |  |  |  |
| Extremities |  |  |  |
| Chest | Thorax |  |  |  |
| Nipples |  |  |  |
| Breasts |  |  |  |
| Gastrointestinal | Abdomen |  |  | **Tanner Stage:**  typical  atypical |
| Liver / Spleen |  |  |
| Anus / Perineum |  |  | X-Ray: Type: Result:Date taken: No Change Date read: Neg/Non-remarkable Date compared with: Improved Worsening  |
| Genitourinary | Male: Scrotum |  |  |
|  Testes |  |  |
|  Penis |  |  |
|  Prostate |  |  |
| Female:Genitalia |  |  | **TB Classification:**  TB suspect 0 No TB exposure, not infected I TB exposure, no evidence of infectionII TB infection, without diseaseIII TB, clinically activeIV TB, not clinically active Site of infection: Pulmonary \_\_Cavity \_\_Non Cavity  Other:  |
|  Vagina |  |  |
|  Cervix |  |  |
|  Uterus |  |  |
|  Adnexa |  |  |
| **ASSESSMENT:** |
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|  |
| **PLAN:** |
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| **Testing today:**  N/A GC/Chlamydia urine  GC/Chlamydia swab  UA  Hep C  TST  VDRL  HIV  Pap Lead  Hgb  Cholesterol  Blood Glucose  Urine PT / UCG: + - Planned?  Yes  NoWet MountOther:  | **Medications/Supplies:**  N/A MV / Folic AcidNumber of bottles given\_\_\_\_\_  Birth Control Method \_\_\_\_\_\_\_\_\_\_ given Rx Foam Issued (#) \_\_\_\_\_\_\_ Condoms Issued (#) \_\_\_\_\_\_\_ Foam/Condoms offered;  pt. declined Other: | **Recommendations made to client, for scheduling of follow-up testing and procedures, based on assessment:**  N/A Vision  Hearing  FBS /GTT Dental  Lipid Screen  Hgb  Pap Smear  Sickle Cell  Lead Mammogram  Ultrasound  UCG/HCG  TST / CXR Bone Density  Liver Panel Blood Glucose  Colorectal Scr. Ovarian Cancer Scr  Other: | **Referrals made:**  N/A PCP, Medical Home HANDS  WIC  Pediatrician  FP  Specialist:  Radiology  MNT with RD  Medicaid  Social Services  1-800-QUIT-NOW  Freedom from Smoking  Other:  |
|  **Healthcare Provider Signature: Date: Recommended RTC:**  |