Patient Label

ADULT INITIAL HISTORY AND PHYSICAL

Today's Date: _____ / _____ / _____ Age: _____ Family Doctor: _____ ☐LEP: Interpreter _____

Please complete the following information:

What is the main reason for your visit today?

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
❑ Fatigue
❑ Difficulty sleeping
❑ Fever/chills
❑ Night sweats
❑ Recent weight change

EYES
❑Blurred or double vision
❑Dryness / Redness
❑ Wear glasses or contacts
❑ Cataracts
❑ Glaucoma

EARS/NOSE/MOUTH/THROAT
❑Earaches or drainage
❑Ringing in the ears
❑Hearing loss
❑Sinus infections/problems
❑Nosebleeds
❑Frequent sore throat
❑Dryness of the mouth
❑Bad breath/bad taste
❑Mouth sores/ulcers
❑Voice changes
❑Bleeding gums
❑Difficulty swallowing
❑Dentures

HEAD, FACE, NECK
❑ Headaches
❑ Reduced facial strength
❑ Recent hair loss
❑ Scalp tenderness
❑ Swollen glands in the neck

CHEST/BREAST
❑ Breast discharge
❑ Breast lump
❑ Breast pain
❑ Breast implants

GASTROINTESTINAL
❑ Heartburn or indigestion
❑ Loss of appetite
❑ Abdominal pain
❑ Changes in bowel habits
❑ Painful bowel movements
❑ Constipation
❑ Frequent diarrhea
❑ Hemorrhoids/blood in stool
❑ Nausea or vomiting
❑ Abnormal liver tests/ liver disease

ENDOCRINE
❑ Diabetes
❑ Thyroid disease
❑ Excessive thirst
❑ Change in tolerance to hot/cold weather

CARDIOVASCULAR
❑ Angina or heart attack
❑ Chest pain or pressure
❑ Fast or irregular heart beat
❑ Swelling of feet / ankles
❑ Poor circulation
❑ Blood clots
❑ High blood pressure

GENITOURINARY
❑ Burning or painful urination
❑ Blood or pus in urine
❑ Incontinence or dribbling
❑ Vaginal discharge
❑ Irregular periods
❑ Painful periods
❑ Prostate problems
❑ Testicular pain
❑ Sexual difficulty
❑ Genital rash or ulcers

SKIN
❑ Rash or itching
❑ Change in moles
❑ Change in skin color
❑ Psoriasis
❑ Skin nodules or bumps
❑ Easy bruising
❑ Sores that won't heal

RESPIRATORY
❑Asthma or Wheezing
❑ Difficulty breathing
❑ Cough with mucous production
❑ Chronic or frequent coughs
❑ Dry cough
❑ Pain on breathing
❑ Spitting/coughing blood

MUSULOSKELETAL
❑ Back pain
❑ Cold extremities
❑ Numbness or tingling
❑ Paralysis
❑ Joint pain
❑ Joint stiffness or swelling
❑ Weakness of muscles or joints
❑ Walk with assistive device
❑ Difficulty climbing stairs

NEUROLOGICAL / PSYCHIATRIC
❑Convulsions or seizures
❑Tremors
❑Memory loss or confusion
❑Light headed/ Dizziness
❑Loss of consciousness
❑Stroke
❑ Depression

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							
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:							

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 ❑No

First 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:

TO BE COMPLETED BY HEALTHCARE PROVIDER

FEMALES ONLY

Age of menarche:
Days between periods: # Days of bleeding:
Problems with menses: ❑ yes ❑ no
Describe:

Age at first pregnancy:
G Para SAB ETP
living children:

Hx of NTD: ❑ yes ❑ no

Age at last pregnancy:
Date of last delivery:

Fertility problems: ❑ yes ❑ no
Describe:

Currently using contraception: ❑ yes ❑ no
Type:

Interruption in B/C method? ❑ yes ❑ no Describe:

Menopausal symptoms: ❑ yes ❑ no
Describe:

HRT: ❑ yes ❑ no
Type:

Age at final menses:

Rubella status: ❑ immune ❑ unknown

DES Exposure: ❑ yes ❑ no ❑ unknown

Routine Pap Tests: ❑ yes ❑ no
Most recent date / Year: Result:

Hx of abnl pap / HPV: ❑ yes ❑ no
Date / Year: Result:

Hx of colposcopy/biopsy: ❑ yes ❑ no
Date / Year: Result:

Mother,sister,daughter with breast cancer < age 50? ❑ yes ❑ no

Currently breastfeeding: ❑ yes ❑ no
Ever breastfed: ❑ yes ❑ no

Routine Mammograms: ❑ yes ❑ no
Most recent date / Year: Result:

Hx of abnl mammogram / CBE: ❑ yes ❑ no
Date / Year: Result:

Hx of breast biopsy: ❑ yes ❑ no
Date / Year: Result:

FOBT: ❑ yes ❑ no Year: Result: ❑ pos ❑ neg

Colonoscopy: ❑ yes ❑ no Year: Result:

MALES ONLY

living children:

Fertility problems: ❑ yes ❑ no
Describe:

Hx of testicular biopsy: ❑ yes ❑ no
Date / Year:
Result:

PSA testing: ❑ yes ❑ no
Most recent date / year:
Result:

Hx of abnl PSA: ❑ yes ❑ no
Date / Year:
Result:

Digital rectal exams: ❑ yes ❑ no
Most recent date / year:
Result:

Hx of abnl digital rectal exam: ❑ yes ❑ no
Date / Year:
Result:

Sigmoidoscopy: ❑ yes ❑ no
Date / Year:
Result:

FOBT: ❑ yes ❑ no Year:
Result: ❑ pos ❑ neg

Colonoscopy: ❑ yes ❑ no Year:
Result:

SEXUAL HISTORY

Sexual partners: ❑ men ❑ women ❑ both

Sexual partners: lifetime_____ last year_____
last 60 days _____ last 30 days _____

Sex with anonymous partners: ❑ yes ❑ no

First sexual contact <18 yrs of age: ❑ yes ❑ no

Bleeding, spotting, pain with intercourse: ❑ yes ❑ no
Describe:

Condoms used routinely: ❑ yes ❑ no

Hx of STDs: ❑ yes ❑ no
Hx of ≥ 2 STDs: ❑ yes ❑ no
Disease(s):

HIV tested: ❑ yes ❑ no Most recent date:
Result: ❑ pos ❑ neg
Unprotected sex since last test: ❑ yes ❑ no

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

ABUSE, NEGLECT, VIOLENCE: (*sexually active minors only) :* Age of partner: _____

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

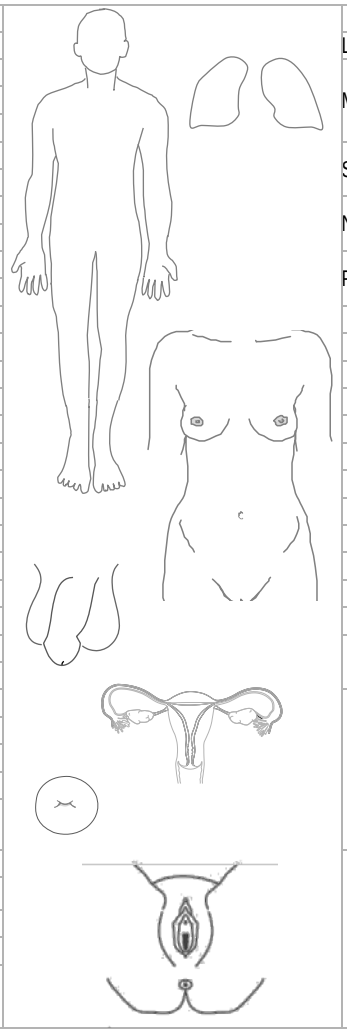
Patient verbalizes understanding of education given ❑

Healthcare Provider Signature: Date:

SUBJECTIVE / PRESENTING PROBLEM:

OBJECTIVE: General Multi-System Examination

SYSTEM		NL	ABNORMAL
Constitutional	General appearance		
	Nutritional status		
	Vital signs		
HEENT	Head: Fontanels, Scalp		
	Eyes: PERRL		
	Conjunctivae, lids		
	Ear: Canals, Drums		
	Hearing		
	Nose: Mucosa/ Septum		
	Mouth: Lips, Palate		
	Teeth, Gums		
	Throat: Tonsils		
Neck	Overall appearance		
	Thyroid		
Respiratory	Respiratory effort		
	Lungs		
Cardiovascular	Heart		
	Femoral/Pedal pulses		
	Extremities		
Chest	Thorax		
	Nipples		
	Breasts		
Gastrointestinal	Abdomen		
	Liver / Spleen		
	Anus / Perineum		
Genitourinary	Male: Scrotum		
	Testes		
	Penis		
	Prostate		
	Female:Genitalia		
	Vagina		
	Cervix		
	Uterus		
	Adnexa		



SYSTEM		NL	ABNORMAL
Lymphatic	Neck,Axilla,Groin AC		
Musculoskeletal	Spine		
	ROM		
	Symmetry		
Skin / SQ Tissue	Inspection(rashes)		
	Palpation (nodules)		
Neurological	Reflexes		
	Sensation		
Psychiatric	Orientation		
	Mood / Affect		

EXPLANATION OF ABNORMAL FINDINGS:

Tanner Stage: ❑ typical ❑ atypical

X-Ray: Type: Result:
Date taken: ❑No Change
Date read: ❑Neg/Non-remarkable
Date compared with: ❑Improved
❑Worsening

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:

ASSESSMENT:

PLAN:

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 Acid
Number 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: