Patient Label

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:

Since your last visit, have you had any hospitalizations, major injuries, or surgeries? ❑ yes ❑ no
If you answered yes, please briefly explain:

Since your last visit, please check if there have there been major **health** changes for the following:
❑Patient (you) ❑Parent ❑ Sister/ Brother ❑Child ❑Grandparent ❑None
Please describe any changes:

Since your last visit, please check if you have had major changes in the following:
❑Educational Status ❑Employment status ❑Marital status ❑Living conditions ❑None
Please describe any changes:

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? _____

Patient Signature: **Date:**

TO BE COMPLETED BY HEALTHCARE PROVIDER

Immunization Status: ❑ Up to date by patient report
❑ Records Requested
❑ See Vaccine Administration Record
❑ Vaccines given today

Lead Assessment:
Verbal Risk Assessment:❑ neg ❑ pos ❑NA
Tested Today: ❑ yes ❑ no
Referred for testing: ❑ yes ❑ no

Preventive Health Education: topics discussed today

❑ Child development
❑ Immunizations
❑ Dental
❑ Hearing/Vision
❑ Lead exposure (ACH-25a)
❑ Diet / Nutrition
❑ Physical activity
❑ Safety
❑ Mental Health
❑ DV/SA
❑ ATOD / Cessation / SHS
❑ Diabetes
❑ Preconception /Folic Acid
❑ Prenatal / Genetics
❑ CVD
❑ Arthritis
❑ Osteoporosis
❑ Cancer
❑ Pelvic / Pap
❑ SBE /Mammogram
❑ STE / PSA
❑ HRT
❑ STD / HIV
❑ Reproductive Life Plan
❑ Options Counseling

Educational Handouts:
❑ FPEM ❑ PTEM
❑ CSEM ❑ Other:

Patient Verbalizes Understanding of Education given ❑

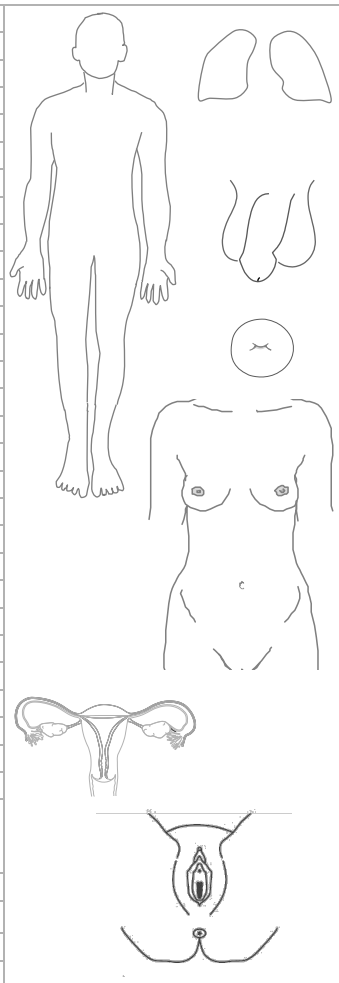
❑ MINOR Family Planning: ❑ Sexual coercion. ❑ Abstinence. ❑ Benefits of parental involvement.

Healthcare Provider Signature: **Date:**

SUBJECTIVE / PRESENTING PROBLEM:

OBJECTIVE: **General Multi-System Examination**

SYSTEM		WNL	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		
Gastro-intestinal	Abdomen		
	Liver / Spleen		
	Anus / Perineum		
Genitourinary	Male: Scrotum		
	Testes		
	Penis		
	Prostate		
	Female:Genitalia		
	Vagina		
	Cervix		
	Uterus		
	Adnexa		



SYSTEM		WNL	ABNORMAL
Lymphatic	Neck, Axilla, Groin		
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:

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

ASSESSMENT:

PLAN:

Testing today: ❑ N/A
❑ GC /Chlamydia urine
❑ GC/Chlamydia swab
❑ UA ❑ TST
❑ VDRL ❑ HIV ❑ Hep C
❑ Pap ❑Lead
❑ Hgb ❑ Cholesterol
❑ Blood Glucose
❑ Urine PT / UCG: ❑Pos ❑Neg
Planned pregnancy? ❑ 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 ❑ Other:
❑ UCG/HCG ❑ TST / CXR
❑Bone Density ❑ Liver Panel
❑Blood Glucose ❑ Colorectal Scr.
❑Ovarian Cancer Scr. :

Referrals made: ❑ N/A
❑ PCP/Medical Home
❑ Pediatrician ❑ WIC
❑ Specialist: ❑ FP
❑ Radiology ❑ Medicaid
❑ MNT with RD ❑ HANDS
❑ Social Services
❑ 1-800-QUIT-NOW
❑ Freedom from Smoking
❑ Other:

Healthcare Provider Signature: **Date:** **Recommended RTC:**