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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 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:** | | | | | | | | | | | |

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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  no  Describe: | # living children: | | |
| Fertility problems:  yes  no  Describe: | | |
| Hx of testicular biopsy:  yes  no  Date / Year:  Result: | | |
| Age at first pregnancy:  G Para SAB ETP  # living children: |
| PSA testing:  yes  no  Most recent date / year:  Result: | | |
| Hx of NTD:  yes  no |
| Age at last pregnancy:  Date of last delivery: |
| Hx of abnl PSA:  yes  no  Date / Year:  Result: | | |
| Fertility problems:  yes  no  Describe: |
| Currently using contraception:  yes  no  Type: | Digital rectal exams:  yes  no  Most recent date / year:  Result: | | |
| Interruption in B/C method?  yes  no Describe: |
| Menopausal symptoms:  yes  no  Describe: | Hx of abnl digital rectal exam:  yes  no  Date / Year:  Result: | | |
| HRT:  yes  no  Type: |
| Sigmoidoscopy:  yes  no  Date / 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  no  Most 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  no  Date / 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  no  Ever breastfed:  yes  no | Sex with anonymous partners:  yes  no | | |
| First sexual contact <18 yrs of age:  yes  no | | |
| Routine Mammograms:  yes  no  Most recent date / Year: Result: | Bleeding, spotting, pain with intercourse:  yes  no  Describe: | | |
| Hx of abnl mammogram / CBE:  yes  no  Date / Year: Result: | Condoms used routinely:  yes  no | | |
| Hx of STDs:  yes  no  Hx of > 2 STDs:  yes  no  Disease(s): | | |
| Hx of breast biopsy:  yes  no  Date / Year: Result: |
| FOBT:  yes  no Year: Result:  pos  neg | HIV tested:  yes  no Most recent date:  Result:  pos  neg  Unprotected 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 ChangeDate read: Neg/Non-remarkableDate 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 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:** | | | | | | | | | | | |