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 ❑ Folic Acid ❑ 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:							

Please ✓ or describe all that apply.

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 (cigarettes, cigars, pipe, dip, chew, snuff) ❑Never used ❑ Exposed to smoke
❑Never used ❑ Exposed to smoke
❑ Past user: type _____
❑Use now: type_____
(# per day _____)

Alcohol or Street Drugs
❑None
❑ Seldom: type_____
❑Occasional: type_____
❑Frequent : type_____

Mental Health: (*in past 90 days)*
❑No Problem
❑Mild/Moderate Depression
❑Severe Depression
❑ 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: ❑Yes ❑No

Males only: Do you examine your testicles every month?
❑Yes ❑No

Females only: Do you examine your breasts every month? ❑Yes ❑No
First day of last menstrual period:___/___/___

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

Preventive Health Education: topics discussed today

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

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

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

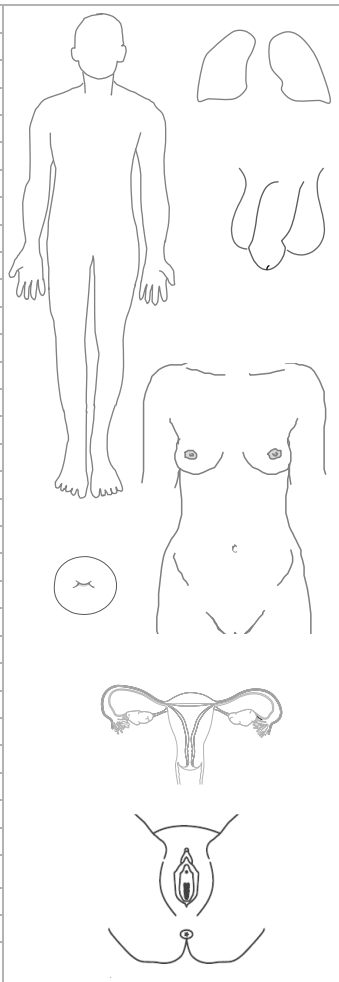
Patient verbalizes understanding of education given ❑

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
❑ UA ❑ TST
❑ VDRL ❑ HIV
❑ Pap ❑Lead
❑ Hgb ❑ Cholesterol
❑ Blood Glucose
❑ Urine PT / UCG: ❑+ ❑-
Planned? ❑ Yes ❑ No
❑Other:

Medications: ❑ N/A
❑ MV / Folic Acid
Number of bottles given_____
❑ Prenatal Vitamins
Number of bottles given_____
❑ Birth Control Method given:_____
❑ 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
❑Bone Density ❑ Liver Panel
❑Blood Glucose ❑ Colorectal Scr.
❑Ovarian Cancer Scr.❑ Other:

Referrals made: ❑ N/A
❑ PMD ❑ HANDS
❑ Pediatrician ❑ WIC
❑ Specialist: ❑ FP
❑ Radiology
❑ MNT with RD
❑ Medicaid
❑ Social Services
❑ 1-800-QUIT-NOW
❑ Cooper Clayton Classes
❑ Other:

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