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:

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 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: **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	❑ 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:

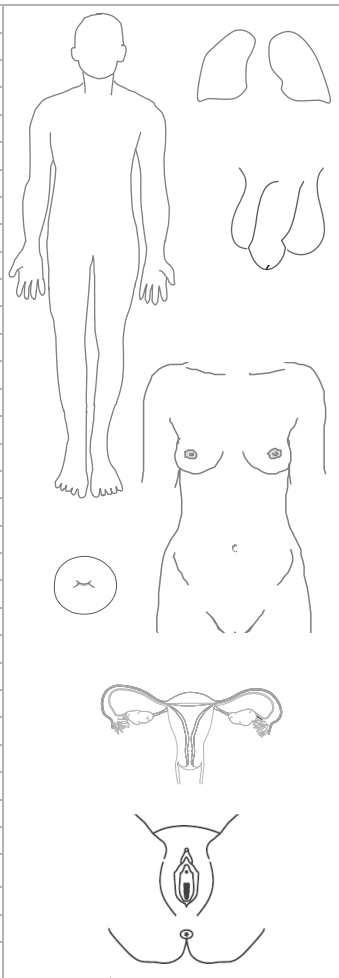
Patient Verbalizes Understanding of Education given ❑

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		
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: ❑Pos ❑Neg
Planned pregnancy? ❑ Yes ❑ No
❑Other:

Medications: ❑ N/A
❑ MV / Folic Acid
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 ❑ Medicaid
❑ MNT with RD
❑ Social Services
❑ 1-800-QUIT-NOW
❑ Cooper Clayton Classes
❑ Other:

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