ADULT INITIAL HISTORY & PHYSICAL

This document is a digitally accessible version of the H&P13 (Print only) used in health departments.

Patient Visit Information Form

Patient Information

Patient Name?
Patient Date of Birth?
Date of Service?
Limited English Proficiency? Yes or No
Name of Interpreter and Language?
Name of Primary Care Physician?
Age?
Reason for today's visit?
Allergies to medications or foods?
Medications you currently take?
Medical history, current medical conditions, and any hospitalizations?
Changes in your health or life since your last visit?
Family health history or recent health changes in your family members?
Dental health routine, including brushing, flossing, and regular dental visits?
Recent Travel: Yes or No Have you traveled outside the United States? Yes or No If yes, list the country visited and travel dates:

Nicotine, Drug, and Alcohol Use Screening

Which nicotine products do you use or have used?

- Cigarettes
- Vaping products
- Cigars
- Chewing tobacco
- Dip
- Pipe tobacco
- Nicotine pouches

Best description of your nicotine use?

- Never used
- Occasional use
- Unknown
- Former use (date quit)
- Daily use
- Light daily use (1-10 cigs, or <2ml vapes, or 1-2 cigars, or 1-4 chew/dip, or 1-3 of 4mg pouches)
- Heavy daily use (>19 cigs, or >5ml vapes, or 3 or more cigars, or >7 chews/dips, or >7 pouches of 4mg pouches)

Use of recreational or non-prescribed drug use?

- Type of drug
- Amount used
- Method of use (injection, by mouth, inhalation, or other)

Use of alcohol?

- Type of alcohol
- Amount of alcohol and how often

Mental Health and Risk of Abuse or Exploitation Screenings

During the past 90 days, have you experienced?

- Anxiety
- Depression
- Thoughts of harming yourself
- Thoughts of harming others

Do you currently experience any of the following?

- Verbal abuse
- Physical abuse
- Fear of abuse
- Pressured to have sex
- Forced sexual contact
- Daily needs not being met
- Sex in exchange for money, food, or drugs

Reproductive Life Plan & Use of Birth Control

During the next year, what is your pregnancy intention? (Males: what is the intention for your female partner to become pregnant?)

- Wants to become pregnant
- Does not want to become pregnant
- Ambivalent
- Unsure

Current birth control method? Have you missed any birth control doses? Yes or No
Any problems with birth control? Yes or No
Would you like to discuss birth control during the visit today? Yes or No

Sexual History & Partner History

Describe your condom use:

- Always
- Sometimes
- Never

Number of sexual partners during the past 12 months? How many of those partners whose name or location is unknown?

Date of last sexual encounter? Date of last unprotected sexual encounter?

Type of Sexual Activity During the Last 60 Days?

- Oral sex (given, received, or both)
    - Partners were male, female, or both
- Anal sex (given, received, or both)
    - Partners were male, female, or both
- Genital sex
    - Partners were male, female, or both

Sexually Transmitted Infection (STI) History and Screening

Your history of:

- Chlamydia
- Gonorrhea
- Syphilis
- Herpes
- Human papillomavirus (HPV) or genital warts
- Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS)
- Trichomoniasis
- Other
- No history of STI

If a history of STI, did you receive treatment? Yes or No

- Date of last treatment

Date of last HIV test?

Indicate whether any sexual partner has a history of:

- STI
- HIV
- Hepatitis C
- Drug Use Injection
- Multiple sexual partners
- Unknown history
- No concerns

Describe any symptoms you are experiencing, including:

- Burning or pain with urination
- Discharge
- Itching
- Odor
- Sores
- Rash or bumps
- Frequent urination

- Genital or testicular pain
- Other symptoms

Symptom start date?

What have you done to relieve the symptoms?

Female Patients Only

First day of last menstrual period?

Any bleeding or spotting between periods?

Problems with periods?

Are periods regular?

Amount of menstrual bleeding?

- Light
- Medium
- Heavy (If heavy, number of heavy days?)

Pregnancy status?

- Unknown
- Pregnant
- Not pregnant
- Pregnant within the past 12 months (Date of delivery, if applicable):

Medical Conditions That Apply to You or Your Blood Relatives

Write in the appropriate letter (C,B,S,M,F or G) next to the condition that applies to you or your blood relatives. **Self** = Me, **Child** = C, **Brother** = B, **Sister** = S, **Mother** = M, **Father** = F, **Grandparent** = G.

- Alcohol, Drug Addiction
- Alzheimer's
- Arthritis
- Asthma
- Birth Defects
- Bleeding Disorder or Free Bleeder
- Cancer
- COPD, Emphysema or Chronic Bronchitis
- Diabetes
- Epilepsy, Convulsions, Seizures
- Heart Attack, Stroke
- High Blood Pressure
- High Cholesterol
- HIV, AIDS
- Kidney Disease
- Liver Disease, Hepatitis
- Mental Illness, Depression
- Osteoporosis

- Sickle Cell
- Thyroid Disorder
- Tuberculosis (TB)
- Other:

Have you ever sought treatment for any of the following?

Fatigue?
Difficulty sleeping?
Fever or chills?
Night sweats?
Recent weight change?
Headaches?
Reduced facial strength?
Recent hair loss?
Scalp tenderness?
Swollen glands in neck?
Breast discharge?
Breast lump?
Breast pain?
Breast implants?
Back pain?
Cold extremities?
Numbness or tingling?
Paralysis?
Joint pain?
Joint stiffness or swelling?
Muscle weakness?
Joint weakness?
Walk with assistive device?
Difficulty climbing stairs?
Earaches or drainage?
Ringing in ears?
Hearing loss?
Sinus infections or problems?
Nosebleeds?
Frequent sore throat?
Dry mouth?
Bad breath or taste?
Mouth sores or ulcers?
Voice changes?
Bleeding gums?
Difficulty swallowing?
Dentures?
Blurred or double vision?
Eye dryness or redness ?
Wear glasses or contacts?
Cataracts?
Glaucoma?

Skin rash or itching?
Change in moles?
Change in skin color?
Psoriasis?
Skin nodule or bumps?
Easy bruising?
Sores that will not heal?
Chest pain or pressure?
Fast or irregular heartbeat?
Swelling of ankles or feet?
Poor circulation?
Blood clots?
Burning with urination?
Pain with urination?
Blood or pus in urine?
Lack of urine control?
Vaginal discharge?
Irregular periods?
Painful periods?
Prostate problems?
Testicular pain?
Sexual difficulty?
Genital rash or ulcers?
Excessive thirst?
Change in tolerance to cold or heat?
Heartburn or indigestion?
Loss of appetite?
Abdominal pain?
Changes in bowel habits?
Painful bowel movement?
Constipation?
Frequent diarrhea?
Hemorrhoids or bloody stool?
Nausea or vomiting?
Abnormal liver tests?
Tremors?
Memory loss or confusion?
Lightheadedness or dizziness?
Loss of consciousness?
Difficulty breathing?
Cough with mucous?
Chronic or frequent cough?
Pain with breathing?
Spitting or coughing blood?

Healthcare Provider Section

Age of partner for sexually active minors?
Risk of exploitation for minors (encouraged for high risk)? Yes or No

Immunization status:

- Up to date - Yes or No
- See vaccine record - Yes or No
- Vaccine given -Yes or No

Gravida?
Para?
Abortions?
Living children?
Problems with birth control?

- ACHES (see CSG for acronyms)? Yes or No
- PAINS (see CSG for acronyms)? Yes or No

Subjective Assessment.
Objective Assessment.

Physical Examination

Area to document abnormal findings for the following:

- General appearance
- Nutritional status
- Vital signs
- Height
- Weight
- Body Mass Index
- Head/Scalp
- Eyes
- Conjunctivae/Lids
- Ears
- Hearing
- Nose (mucosa/septum)
- Mouth (lips/palate)
- Teeth
- Gums
- Throat
- Thyroid
- Respiratory effort
- Lungs
- Heart
- Femoral pulse
- Pedal pulse
- Extremities
- Thorax
- Nipples
- Breast
- Abdomen
- Liver/Spleen
- Anus/Perineum
- Skin/Subcutaneous Tissue
- Musculoskeletal

    - Spine
    - Range of Motion
    - Symmetry
- Lymphatic nodes/Palpation
- Reflexes/Sensation
- Male
    - Scrotum
    - Testes
    - Penis
    - Prostate
- Female
    - Genitalia
    - Vagina
    - Cervix
    - Uterus
    - Adnexa
- Psychiatric
    - Orientation
    - Mood
    - Affect

Estimated due date (if applicable)?
Laboratory results?
Notes.
Assessment.
Plan.
Preventive Health.

History of Tests and Screenings

(This section is not required for Family Planning visits.)
Date and results of the most recent:

- Pap test/HPV screening
- Colonoscopy
- Mammogram

Cancer Risk Assessment

- Age at first sexual intercourse
- Age at first menstrual period
- Number of lifetime sexual partners
- Breast self-awareness discussed - Yes or No
- Abnormal vaginal bleeding - Yes or No
- DES exposure - Yes or No
- Family history of breast cancer - Yes or No

Tuberculosis Risk: If symptoms such as cough, fever, night sweats, or shortness of breath are reported, initiate the TB Risk Assessment (TB-4) and perform TB testing as indicated per TB-4.

Lead Exposure Assessment: Document verbal risk assessment findings (positive/negative, or N/A).

Education and Counseling

Document counseling provided, including topics such as:

- None
- Adolescent:
    - Abstinence
    - Consent and prevention of sexual coercion
    - Family or trusted adult involvement
- Pregnancy
    - Pregnancy Test Education Material (PTEM)
    - Pregnancy options counseling
- General
    - Abuse
    - Alcohol, tobacco, and other drugs
    - Smoking cessation
    - Secondhand smoke exposure
    - Condoms to prevent pregnancy & sexually transmitted infections
    - Contraception
    - Cancer screening education material (CSEM)
    - Family planning education material (FPEM19)
    - Folic acid
    - Hepatitis C
    - HIV testing and counseling
    - Human trafficking
    - Immunizations
    - Lead exposure
    - Mental health
    - Partner notification
    - Preconception counseling
    - Provider referrals
    - Sexually transmitted infection education material (STIEM)
    - Counseling to achieve pregnancy

Education provided by:
Patient verbalized understanding? Yes or No

Referrals

- None
- DCBS
- Dental
- Dietician
- Family Planning
- HANDS
- Mental Health
- OB/GYN/PAP
- PCP/Provider

- Pregnancy Resources
- Presumptive Eligibility
- Safety
- WIC
- Other

Testing Performed Today

Document any testing completed, including:

- None
- Gonorrhea and chlamydia testing
    - Urine
    - Swab
- Wet mount (swab: anal, genital, or throat)
- Blood glucose
- Hemoglobin
- Hepatitis C
- Hearing
- Lipid screening
- Pap test
- HIV
- Pregnancy testing
- HPV
- Herpes culture
- Liver panel
- Syphilis treponema pallidum testing
- Serology for Syphilis (VDRL/RPR)
- Urinalysis
- Vision testing
- Other tests

Recommendations

Document recommended screenings or follow-up, including:

- None
- Bone density
- Colorectal screening
- Dental examination
- Blood glucose
- Hemoglobin
- Lipid screening
- Mammogram
- Pap test
- Smoking cessation
- STI testing
- Urine pregnancy testing
- Chest X-ray

- Other recommendations

Medications and Supplies Provided

Document medications or supplies provided, including:

- Number of birth control
- Birth control type
- Number of condoms
- Condoms declined
- Number of multivitamins or folic acid
- Number of contraceptive films
- Bicillin dose and site
- Rocephin dose and site
- Doxycycline dose
- Metronidazole dose
- Azithromycin (Zithromax) dose
- Emergency contraception dose
- Other medications
- Prescriptions

Medication benefits, side effects, and adverse reactions discussed? Yes or No

Additional Information

Birth control method at exit?

If no birth control method at exit, reason for no method?

- Abstinence
- Seeking pregnancy
- Same-sex partner
- Pregnant
- Sterile for a non-contraceptive reason
- Other

How was contraception provided?

- In person/on site
- Referral to another provider
- Prescription