ADULT INITIAL HISTORY AND PHYSICAL

Patient Name________________________
Patient DOB ________________________

Date of Service ____________ Limited English Proficiency? ☐ Yes ☐ No Interpreter/Language ____________ PCP ____________

SECTION A: COMPLETED BY THE PATIENT FOR ALL VISITS

Age ____ Reason for visit?

Allergies to medicines or foods ________________

Medications ________________

Medical History/Conditions/Hospitalizations________________

List any health or life changes:________________

Major health history or changes in family members:

Nicotine (cigarettes, vape, cigars, chew, dip, pipe)	**Alcohol**	**Street Drugs** ❑ N/A	**Mental Health** ❑ N/A
❑ Never ❑ Exposed to second-hand smoke ❑ Current User: Type & Amount__________ ❑ Former User: Type & Amount__________ Date quit __________	❑ N/A ❑ Type/Amount	❑ Type/Amount__________ **Injectable Drugs** ❑ N/A ❑ Type/Amount__________	❑ Anxiety/Depression ❑ Thoughts of harming self ❑ Thoughts of harming others ❑ Past 90 days

Abuse/Neglect/Violence: ❑ No abuse

Do you experience any of the following:

❑ Verbal or physical abuse ❑ Sex for money, food or drugs
❑ Fear of abuse ❑ Pressure to have sex
❑ Forced sexual contact ❑ Daily needs unmet

Females Only - First day of last menstrual period __________
Are your periods regular? ❑ Yes ❑ No **# days between periods** ______
Amount of bleeding ❑ Light ❑ Medium ❑ Heavy **# of days** __________
Problems with periods? __________
Any bleeding/spotting between periods? ❑ Yes ❑ No

Reproductive Life Plan How many children do you want? ______________ What do you use for birth control? ______________
How many children do you have? ______________ Would you like to discuss birth control methods? ❑ Yes ❑ No
Any break in your birth control method? ❑ Yes ❑ No Plans to be pregnant within the next year? ❑ Yes ❑ No
Problems with birth control now or in the past?

<u>SECTION B</u>: Pregnancy test only visit STOP HERE. All other visits continue to complete this section.

Symptoms or problems ❑ None ❑ Frequent urination ❑ Burning/Pain with urination ❑ Discharge ❑ Itch ❑ Odor ❑ Pain (genital/testicle) ❑ Rash/Bumps ❑ Sores ❑ Other__________

Symptom Start Date _________ What have you done to relieve symptoms?

Sexual History: Condom Use: ❑ Always ❑ Sometimes ❑ Never	**Partner(s) History:**	**STI History:** ☐ None
Date of last sex **encounter**________ Date of unprotected sex _______ **Past 60 DAYS**: Sexual partners ______ Number of Male Partners ______ Number of female partners ________ Number of new partners ________ Number of partners with unknown name or location _______ Anal sex within last ❑ N/A ❑ 60 days ❑ 12 months Oral sex within last ❑ N/A ❑ 60 days ❑ 12 months Genital sex within last ❑ N/A ❑ 60 days ❑ 12 months	☐ No concerns ☐ STI ☐ HIV ☐ Hepatitis C ☐ IV Drug Use ☐ Multiple Partners ☐ Unknown History	**Check any STIs you have had** ☐ Chlamydia ☐ HIV/AIDS ☐ Herpes ☐ HPV/Genital Warts ☐ Gonorrhea ☐ Syphilis ☐ Trichomoniasis ☐ Other__________ **Did you receive treatment?** ☐ N/A ☐ No ☐ Yes, Date:

Write in the appropriate letter (C,B,S,M,F,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

HIV/AIDS: ❑ No ❑ Yes Who:	Heart Attack/Stroke: ❑ No ❑ Yes Who:
Alcohol/Drug Addiction: ❑ No ❑ Yes Who:	High Blood Pressure: ❑ No ❑ Yes Who:
Alzheimer's: ❑ No ❑ Yes Who:	High Cholesterol: ❑ No ❑ Yes Who:
Arthritis: ❑ No ❑ Yes Who:	Kidney Disease: ❑ No ❑ Yes Who:
Asthma: ❑ No ❑ Yes Who:	Liver Disease/Hepatitis: ❑ No ❑ Yes Who:
Birth Defects: ❑ No ❑ Yes Who:	Mental Illness/Depression: ❑ No ❑ Yes Who:
Bleeding Disorder/Free Bleeder: ❑ No ❑ Yes Who:	Osteoporosis: ❑ No ❑ Yes Who:
Cancer: ❑ No ❑ Yes Who:	Sickle Cell: ❑ No ❑ Yes Who:
COPD/Emphysema/Chronic Bronchitis: ❑ No ❑ Yes Who:	Thyroid Disorder: ❑ No ❑ Yes Who:
Diabetes: ❑ No ❑ Yes Who:	Tuberculosis/TB: ❑ No ❑ Yes Who:
Epilepsy/Convulsions/Seizures: ❑ No ❑ Yes Who:	Other:

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Check if you have ever sought treatment for any of the following: ❑ None

Constitutional
❑ Fatigue
❑ Difficulty sleeping
❑ Fever/Chills
❑ Night sweat
❑ Recent weight change

Head/Face/Neck
❑ Headaches
❑ Reduced facial strength
❑ Recent hair loss
❑ Scalp tenderness
❑ Swollen glands in neck

Chest/Breast
❑ Breast discharge
❑ Breast lump
❑ Breast pain
❑ Breast implants

Musculoskeletal
❑ 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

Ear/Nose/Mouth/Throat
❑ Earaches or drainage
❑ Ringing in ears
❑ Hearing loss
❑ Sinus infections/problem
❑ Nosebleeds
❑ Frequent sore throat
❑ Dry mouth
❑ Bad breath/taste
❑ Mouth sores/ulcers
❑ Voice changes
❑ Bleeding gums
❑ Difficulty swallowing
❑ Dentures

Eyes
❑ Blurred/double Vision
❑ Dryness/redness
❑ Wear glasses/contacts
❑ Cataracts
❑ Glaucoma

Skin
❑ Rash/Itching
❑ Change in moles
❑ Change in skin color
❑ Psoriasis
❑ Skin nodule/bumps
❑ Easy bruising
❑ Sores that won't heal

Cardiovascular
❑ Chest pain or pressure
❑ Fast or irregular heartbeat
❑ Swelling of ankles/feet
❑ Poor circulation
❑ Blood clots

Gastrourinary
❑ 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

Endocrine
❑ Excessive thirst
❑ Change in tolerance to cold
❑ Change in tolerance to heat

Gastrointestinal
❑ Heartburn or indigestion
❑ Loss of appetite
❑ Abdominal pain
❑ Changes in bowel habits
❑ Painful bowel movement
❑ Constipation
❑ Frequent diarrhea
❑ Hemorrhoids/Bloody stool
❑ Nausea or vomiting
❑ Abnormal liver tests

Neurological/Psychiatric
❑ Tremors
❑ Memory loss or confusion
❑ Lightheadedness/dizziness
❑ Loss of consciousness

Respiratory
❑ Difficulty breathing
❑ Cough with mucous
❑ Chronic or frequent cough
❑ Pain with breathing
❑ Spitting/coughing blood

Reviewed by Healthcare Provider Signature: **Date:**

TO BE COMPLETED BY HEALTHCARE PROVIDER: Shaded area is not required for family planning clients

Cancer Risk Abnormal vaginal bleeding ❑ Yes ❑ No Age started menses________
Family Hx of breast cancer ❑ Yes ❑ No Age of first sex______________
Self-breast awareness ❑ Yes ❑ No DES exposure ❑ Yes ❑ No
Number of lifetime partners _________

Date of Most Recent
Pap_______________ Normal ❑ Yes ❑ No
Colonoscopy________ Normal ❑ Yes ❑ No
Mammogram________ Normal ❑ Yes ❑ No

Tuberculosis Risk: If any s/s of TB (cough, fever, night sweats, shortness of air) are reported, initiate TB Risk Assessment (TB-4), TB test as indicated per TB-4.

Lead Assessment: Verbal Risk Assessment ❑ Neg ❑ Pos ❑N/A

Dental Health ❑ Brush/Floss daily ❑ Regular Dental visit **Travel outside the USA** ❑ Yes ❑ No Country_______Date(s)____________

Testing Today: ❑ None **GC/CT** ❑ Urine ❑ Swab (anal, genital, throat) **Wet Mount** ❑ Swab (anal, genital, throat)
❑ Blood Glucose ❑ Hgb ❑ HCV ❑ Hearing ❑ Lipid Screen ❑ PAP ❑ UCG ❑ VDRL
❑ HCG ❑ HIV ❑ HPV ❑ Herpes Cx ❑ Liver Panel ❑ UA ❑ Vision ❑ Other_________

Recommendations ❑ None ❑ Bone density ❑ Colorectal screen ❑ Dental ❑ Glucose ❑ Hgb ❑ Lipid screen
❑ Other ______________________ ❑ Mammogram ❑ Smoking cessation ❑ PAP ❑ STI ❑ UCG ❑ CXR

Problems with method or ACHES/PAINS ❑ Yes ❑ No
Immunization status ❑ Up to date per pt ❑ See vaccine record ❑ Vaccine given

G _____**P** _____**Ab** _____**L** _____
Date of last HIV test:

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Sexually active minor: Age of partner ______ **Risk of exploitation?** ❑ Yes ❑ No **Preferred method of birth control**

Subjective:

Objective: System Examination		WNL	Abnormal	System Examination		WNL	Abnormal	Notes/Other Findings
Constitutional	General appearance			Gastrointestinal	Abdomen			**EDC:**
	Nutritional status				Liver/Spleen			**Lab Results:**
	Vital signs				Anus/Perineum			
	Height/Weight/BMI			Skin/SQ Tissue	Inspection (rash)			**ASSESSMENT**
HEENT	Head: Scalp			Musculoskeletal	Spine			
	Eyes: PERRLA				ROM			**PLAN**
	Conjunctivae, lids				Symmetry			
	Ear: Canals, Drums			Genitourinary	Male: Scrotum			
	Hearing				Testes			
	Nose: Mucosa/Septum				Penis			**ABNORMAL FINDINGS AND/OR NOTES**
	Mouth: Lips, Palate				Prostate			
	Teeth, Gums				Female: Genitalia			
	Throat: Tonsils				Vagina			
Neck	Thyroid				Cervix			
	Overall appearance				Uterus			
Respiratory	Respiratory effort				Adnexa			
	Lungs			Lymphatic	Nodes			
Cardiovascular	Heart			Neurological	Palpation			
	Femoral/Pedal pulses				Reflexes			
	Extremities				Sensation			
Chest	Thorax			Psychiatric	Orientation			
	Nipples				Mood/Affect			
	Breasts							

Referrals
❑ None

❑ DCBS ❑ Dental ❑ Dietitian
❑ Family Planning ❑ HANDS ❑ Mental Health
❑ PCP/Provider ❑ Pregnancy Resources ❑ Presumptive Eligibility
❑ Safety ❑ Smoking Cessation ❑ Other
❑ WIC ❑ OB/GYN/PAP

Client Centered Education ❑ None **Education provided by** ________________________ **❑Pt verbalizes understanding**

Adolescent: ❑ Abstinence ❑ Consent & Ways to Prevent Sexual Coercion ❑ Family or Trusted Adult Involvement

❑ ATOD/Smoking Cessation/SHS ❑ Folic Acid ❑ Immunization ❑ Preconception
❑ Abuse/DV ❑ HCV ❑ Mental Health ❑ Provider List
❑ Condoms to prevent pregnancy & STI ❑ HIV Pre/Post Test ❑ Partner Notification ❑ Lead Exposure
❑ Contraceptive ❑ Human Trafficking ❑ Opportunity to discuss pregnancy options for **Positive PT**

Education Packets ❑ CSEM (HPV/SBA/PAP/Mamm) ❑ FPEM19 ❑ PTEM ❑ STDEM ❑ Other

Medications/Supplies: ❑ None **❑ Benefits, side effects and adverse reactions to medications discussed**

❑ Birth Control # ______ (type) ______________________________

❑ Condoms #________ ❑ Condoms declined ❑ MV/Folic Acid # _____________ ❑ Films #____________

❑ Bicillin-Dose/Site ________________________ ❑ Rocephin-Dose/Site________________________

❑ Doxycycline-Dose ________________________ ❑ Metronidazole-Dose________________________

❑ Zithromax-Dose________________________ ❑ ECP-Dose________________________

❑ Other________________________ Rx________________________

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