ADULT INTERVAL 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	❑ N/A	❑ Type/Amount_____	❑ Anxiety/Depression
❑ Current User: Type & Amount_____	❑ Type/Amount	_____	❑ Thoughts of harming self
❑ Former User: Type & Amount_____	_____	**Injectable Drugs** ❑ N/A	❑ Thoughts of harming others
Date quit _____	_____	❑ Type/Amount_____	❑ 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?

SECTION B: 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
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

Partner(s) History:
☐ No concerns
☐ STI ☐ HIV
☐ Hepatitis C
☐ IV Drug Use
☐ Multiple Partners
☐ Unknown History

STI History: ☐ None
Check any of the below you have had…
☐ Chlamydia ☐ HIV/AIDS
☐ Herpes ☐ HPV/Genital Warts
☐ Gonorrhea ☐ Syphilis
☐ Trichomoniasis ☐ Other_____
Did you receive treatment
☐ N/A ☐ No ☐ Yes, 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_____
Breast self-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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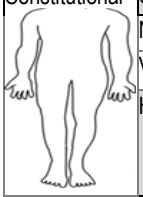
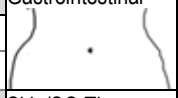
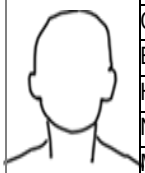
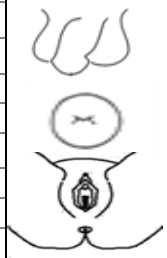
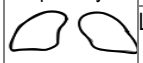
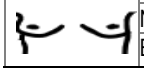
Sexually active minor: Age of partner _____ **Risk of exploitation?** ❑ Yes ❑ No **Preferred method of birth control**

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				Spine			
	Eyes: PERRLA			Musculoskeletal	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				Palpation			
	Femoral/Pedal pulses			Neurological	Reflexes			
	Extremities				Sensation			
Chest	Thorax				Orientation			
	Nipples			Psychiatric	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-_____
❑Other_____ ❑ Rx_____

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