Patient Name_____
Patient DOB _____

ADULT INTERVAL HISTORY AND PHYSICAL

Limited English Proficiency? ☐ Yes ☐ No **Interpreter**_____**PCP:** _____

TO BE COMPLETED BY THE PATIENT

Please answer the following questions to the best of your ability so that we can better serve you.

Age: ____Reason for visit? _____

Check any problems or symptoms you have: ☐ No complaints ☐ Discharge ☐ Odor ☐ Sores ☐ Pain in genital area ☐ Rash ☐ Bumps ☐ Genital itch ☐ Testicle pain ☐ Burning/pain with urination ☐ Frequent urination **Symptom Start Date:** _____
List any symptoms you wish to discuss: _____ **What have you done to relieve symptoms?** _____

Since your last visit have you had changes to following: ☐ Allergies to medicines or foods ☐ Relationship status ☐ Education ☐ Employment ☐ Living conditions ☐ Medical conditions ☐ Hospitalizations, surgeries, procedures ☐ Major injuries ☐ Medications you take-Prescription or OTC
Describe any changes _____
☐ Major health changes in family members: ☐ Parent ☐ Sibling ☐ Child ☐ Grandparent Describe _____

Mental Health: ☐ None ☐ Anxiety ☐ Depression ☐ Thoughts of harming self ☐ Thoughts of harming others ☐ Other: _____

Nicotine use (cigarettes, vape, cigars, pipe, dip, chew) past year: ☐ Type/Amount: _____ ☐ Never ☐ Exposed to second-hand smoke

How often do you drink alcohol?_____ Type/Amount: _____
How often do you use street drugs? (Type/Amount) _____ **IV drugs?** (Type/Amount) _____

Abuse/Neglect/Violence: Are you experiencing any of the following? ☐ No fear of harm ☐ Verbal/physical abuse ☐ Sex for money, food or drugs ☐ Fear of abuse ☐ Pressure to have sex ☐ Forced sexual contact ☐ Daily needs unmet

Reproductive Life Plan: **How many children do you want? _____ How many children do you have? _____**
Do you plan to be pregnant within the next year? ☐ Yes ☐ No **What are you using to prevent pregnancy?** _____
List problems you have/had with any birth control methods now or in the past. _____
Has there been a break in your birth control method? ☐ Yes ☐ No **Would you like to discuss birth control methods?** ☐ Yes ☐ No

ALL QUESTIONS BELOW PERTAIN TO THE PAST 12 MONTHS

Have you had ☐ Genital sex ☐ Oral sex ☐ Anal sex **# of sexual partners** Male _____ Female _____
How many times have you had sex with someone that you do not know the name or how to locate the partner? _____
Partner(s) History: ☐ STI ☐ HIV ☐ Hepatitis C ☐ IV Drug Use ☐ Multiple Partners ☐ Unknown Partner History ☐ No concerns with partner sexual history
How often do you use condoms? ☐ Always ☐ Sometimes ☐ Never
Have you been tested for a sexually transmitted infection (STI)? ☐ Yes ☐ No
For which have you been tested? ☐ None ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HIV/AIDS ☐ HPV/Genital Warts ☐ Syphilis ☐ Trichomoniasis ☐ Other_____ **Were you treated for all positive test(s)?** ☐ Yes ☐ No **HIV Test Date:** _____ **Hepatitis C Test Date:** _____
Dental Health: ☐ Brush daily ☐ Floss daily ☐ Visit dentist every 6 months **Water source:** ☐ Bottled ☐ Cistern ☐ City ☐ Well
Do you have concerns about your weight? ☐ Yes ☐ No **Do you exercise?** ☐ None ☐ Daily ☐ Weekly ☐ Monthly
Check foods you eat every day: ☐ Milk/Dairy ☐ Meats ☐ Vegetables ☐ Fruits ☐ Breads or Grains
Travel outside the USA: ☐ Yes ☐ No Country _____ Date(s) _____

Reproductive Health (Females Only): ☐ No change since last visit **# of pregnancies**___ **# of live births** __ **#abortion/miscarriage**____
First day of last menstrual period: _____ **Are your periods regular?** ☐ Yes ☐ No **#Days of bleeding** _____
List any problems with your menstrual cycle? _____ **Amount of bleeding**: ☐ Light ☐ Medium ☐ Heavy
#Days between bleeding? _____ **What age did you start your menstrual cycle?** ____ **Do you practice self breast awareness?** ☐ Yes ☐ No
Pregnancy Test Visit Only: ☐ Planned Pregnancy? ☐ Yes ☐ No **Was your last PAP normal?** ☐ Yes ☐ No **Date of last PAP** _____

Patient Signature: **Date:**

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

TO BE COMPLETED BY HEALTHCARE PROVIDER

Immunization Status: ❑ Up to date by patient report ❑ Records requested ❑ See Vaccine Administration Record ❑ Vaccines given	**Lead Assessment:** Verbal Risk Assessment: ❑ Neg ❑ Pos ❑NA Tested Today: ❑ Yes ❑ No Referred for testing: ❑ Yes ❑ No
TB Classification: ❑ TB suspect ❑ 0 No TB exposure, not infected ❑ I TB exposure, no evidence of infection ❑ II TB infection, no disease ❑ III TB, clinically active ❑ IV TB, not clinically active Site of infection: ❑Pulmonary Cavity ❑Pulmonary Non Cavity ❑Other	**X-Ray:** Type: _____ Date taken: _____ Date read: _____ Result: _____ ❑Neg/Non-remarkable ❑ Improved ❑No Change ❑ Worsening Date compared with: _____
Any problems with method or ACHES/PAINS? ☐ Yes ☐ No	**Any unprotected sex in last five days?** ☐ Yes ☐ No

Desired birth control method, if different than current method: _____

Cervical Cancer Risk: Age when first had sex____ Abnormal vaginal bleeding ☐ Yes ☐ No Family Hx of Breast Cancer: ☐ Yes ☐ No

Healthcare Provider Signature: **Date:**

Patient Name_____
Patient DOB _____

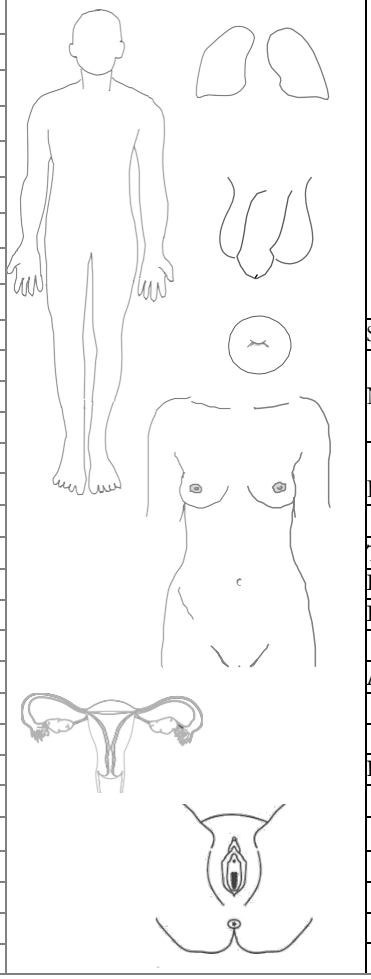
ADULT INTERVAL HISTORY AND PHYSICAL

TO BE COMPLETED BY HEALTHCARE PROVIDER

Sexually active minor: age of partner _____ **Is there a risk of exploitation** ☐ Yes ☐ No If yes, explain_____

Subjective:

Objective: System Examination		WNL	Abnormal
Constitutional	General appearance		
	Nutritional status		
	Vital signs		
	Height/Weight/BMI		
HEENT	Head: Scalp		
	Eyes: PERRL		
	Conjunctivae, lids		
	Ear: Canals, Drums		
	Hearing		
	Nose: Mucosa/Septum		
	Mouth: Lips, Palate		
	Teeth, Gums		
	Throat: Tonsils		
Neck	Thyroid		
	Overall appearance		
Respiratory	Respiratory effort		
	Lungs		
Cardiovascular	Heart		
	Femoral/Pedal pulses		
	Extremities		
Chest	Thorax		
	Nipples		
	Breasts		
Gastrointestinal	Abdomen		
	Liver/Spleen		
	Anus/Perineum		
Lymphatic	Neck, Axilla, Groin		
Musculoskeletal	Spine		
	ROM		
	Symmetry		



System Examination		WNL	Abnormal
Genitourinary	Male: Scrotum		
	Testes		
	Penis		
	Prostate		
	Female: Genitalia		
	Vagina		
	Cervix		
	Uterus		
	Adnexa		
Skin/SQ Tissue	Inspection (rash)		
Neurological	Palpation		
	Reflexes		
	Sensation		
Psychiatric	Orientation		
	Mood/Affect		

Other Findings

Tanner stage: ☐ typical ☐ atypical

Lab Results:

EDC:

ASSESSMENT

PLAN

Testing Today: ☐ None ☐ Blood Glucose ☐ CBE ☐ Chlamydia urine ☐ Chlamydia swab sites_____ ☐ Cholesterol ☐ FBS/GTT ☐ GC urine ☐ GC swab sites _____ ☐ Hearing ☐ Hepatitis C ☐ Herpes Culture ☐ HIV Blood ☐ HIV Oral ☐ HCG ☐ HCV ☐ Hgb ☐ HPV ☐ Lead ☐ Lipid Screen ☐ Liver Panel ☐ PAP ☐ Sickle Cell ☐ TST/CXR ☐ UA ☐ UCG ☐ Vision ☐ VDRL ☐ Wet Mount ☐ Other: _____

Recommendations made to client, for scheduling of follow-up testing and procedures, based on assessment: ☐ None ☐ Blood Glucose ☐ Bone density ☐ Colorectal Screen ☐ Dental ☐ Development Screen ☐ FBS/GTT ☐ HCG ☐ Hearing ☐ Hgb ☐ Lead ☐ Lipid Screen ☐ Liver Panel ☐ Mammogram ☐ Ovarian Cancer Screen ☐ PAP ☐ Sickle Cell ☐ Speech ☐ STI ☐ TST/CXR ☐ UCG ☐ Ultrasound ☐ Vision ☐ Other:

Referrals Made: ☐ None ☐ DCBS ☐ Dental ☐ Dietitian ☐ Family Planning ☐ HANDS ☐ Local Providers List ☐ Medicaid ☐ Mental Health ☐ PCP-Medical Home ☐ Pediatrician ☐ Pregnancy Resource List ☐ Prenatal Program ☐ Presumptive Eligibility ☐ Radiology ☐ Safety ☐ Smoking Cessation ☐ Social Services ☐ WIC ☐ OB/GYN or Other Specialist _____

Client Centered Health Education. Positive PT: ☐ Opportunity to discuss foster, infant, prenatal care; adoption, delivery, pregnancy termination, etc.
Adolescent: ☐ Abstinence ☐ Consent/Sexual Coercion ☐ Parental Involvement, or reason not encouraged documented _____

☐ None	☐ Dental	☐ Immunization	☐ Provider List ☐ PTEM
☐ Arthritis ☐ ATOD Cessation/SHS	☐ Diabetes	☐ Lead Exposure (ACH-25a)	☐ Reproductive Life Plan
☐ Abuse/domestic violence	☐ Diet/Nutrition	☐ Mammogram	☐ Resource numbers
☐ Cancer ☐ CSEM	☐ Folic Acid ☐ Calcium Supplement	☐ Mental Health	☐ Risk reduction/Safety
☐ Cardiovascular disease	☐ FP Options	☐ Osteoporosis	☐ Self breast awareness
☐ Child development	☐ FPEM-19	☐ Partner Notification	☐ Self testicular exam/PSA
☐ Contraceptive education	☐ Hearing	☐ Pelvic/PAP	☐ Social services
☐ Condom use to prevent pregnancy	☐ HCV ☐ HIV/Pretest ☐ HPV	☐ Physical Activity ☐ Preconception	☐ STI
☐ Condom use to prevent STI	☐ Human Trafficking	☐ Prenatal/Genetics	☐ Vision

Patient ☐ Verbalizes understanding ☐ Declines education Education provided by: _____

Medications/Supplies: ☐ None ☐ Birth Control # ____(type)_____ ☐ Rx ☐ Condoms #___ ☐ Condoms/Foam Declined ☐ ECP ☐ Foam # ____ ☐ MV/Folic Acid #____ ☐ Bicillin ☐ Doxycycline ☐ Metronidazole ☐ Rocephin ☐ Zithromax ☐ Other:_____ ☐ Rx_____ ☐ Benefits, side effects and adverse reactions to medications discussed

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