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:_____
Dental Health ❑Brush/Floss daily ❑Regular dental visits **Travel outside the USA** ❑ Yes ❑ No **Country** **Date(s)**

Nicotine (cigarettes, vape, cigars, chew, dip, pipe)	**Alcohol**	**Drug Use** ❑ None	**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_____	_____	❑ Inject ❑ By Mouth	❑ Thoughts of harming others
Date quit		❑ Inhale ❑ Other:	❑ 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

All Patients: Reproductive Life Plan How many children do you: Have? _____Want?_____ Plan to have a child this year? ❑Yes ❑No
What do you use for birth control? _____ Would you like to discuss birth control methods? ❑ Yes ❑ No
Any break in your birth control method? ❑ Yes ❑ No Problems with birth control now or in the past?

Symptoms or Problems ❑ None ❑ Discharge ❑ Itch ❑ Odor ❑ Frequent urination
❑ Burning/Pain with urination ❑ Sores ❑ Rash/Bumps ❑ Pain (genital/testicle) ❑ Other _____
Symptom Start Date What have you done to relieve the symptoms?

Sexual History: Condom Use: ❑ Always ❑ Sometimes ❑ Never
Date of last sex **encounter**_____ Date of unprotected sex _____
Past 60 DAYS: Sexual partners - Number of New Partners_____
Number of Female Partners _____ Number of Male 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 if you had
□ Chlamydia □ HPV/Genital Warts
□ Herpes □ Gonorrhea
□ Syphilis □ Trichomoniasis
□ HIV/AIDS, **Date of last test** _____
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 :

ADULT INITIAL HISTORY AND PHYSICAL

Patient Name_____
Patient DOB _____
Date of Service_____

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_____
Breast self-awareness ❑Yes ❑No DES exposure ❑ Yes ❑ No
Number of lifetime partners _____

Date of Most Recent
Pap/HPV_____ 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

Problems with Birth Control: ACHES ❑ Yes ❑ No or **PAINS** ❑ Yes ❑ No (See CSG for acronym ACHES & PAINS)

Immunization status ❑Up to date per pt ❑See vaccine record ❑Vaccine given **G_____P_____Ab_____L_____**

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 ❑ 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 Pregnancy

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

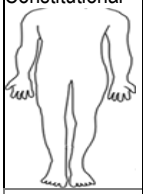
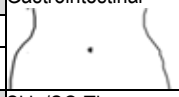
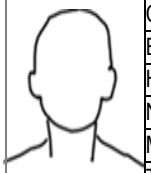
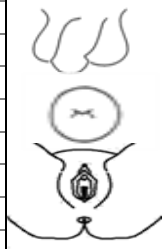
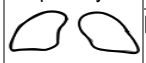
ADULT INITIAL HISTORY AND PHYSICAL

Patient Name_____
Patient DOB _____
Date of Service_____

Sexually active minor: Age of partner _____ **Risk of exploitation?** ❑ Yes ❑ No

Subjective:

Objective:

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

Notes/Other Findings

EDC:

Lab Results:

ASSESSMENT

PLAN

ABNORMAL FINDINGS AND/OR NOTES

Referrals ❑ None ❑ DCBS ❑ Family Planning ❑ OB/GYN/PAP ❑ Pregnancy Resources ❑ Safety ❑ Dental ❑ HANDS ❑ PCP/Provider ❑ Presumptive Eligibility ❑ Smoking Cessation ❑ Dietician ❑ Mental Health ❑ WIC ❑ Other:

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
❑ Mammogram ❑ Smoking cessation ❑ PAP ❑ STI ❑ UCG ❑ CXR ❑ 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** _____ **RTC** _____