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:_____

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 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:

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:

Patient Name_____
Patient DOB _____

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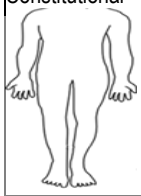
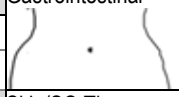
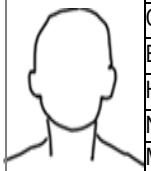
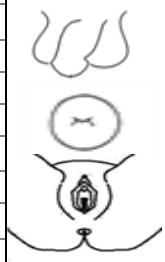
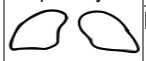
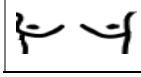
Sexually active minor: Age of partner _____ **Risk of exploitation?** ❑ Yes ❑ No	**Notes/Other Findings**
Subjective:	**EDC:**
	Lab Results:
Objective:	

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			Neurological	Reflexes		
	Femoral/Pedal pulses				Sensation		
	Extremities						
Chest 	Thorax			Psychiatric	Orientation		
	Nipples				Mood/Affect		
	Breasts						

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** _____ **Recommended RTC** _____