

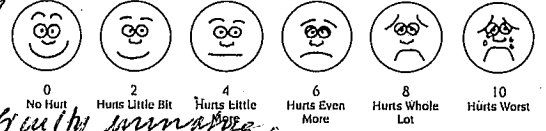
Primary Provider

COMMUNITY HEALTH AIDE/PRACTITIONER PATIENT ENCOUNTER FORM

Clinic Code _____

HISTORY Chief complaint: Thinks she has a urine infection
 Hx of Present Illness: 20 yr. old woman started with burning when peeing yesterday. Burns bad. Only hurts when peeing. Nothing helps. Nothing worse. No treatment. Never had before. No chronic health problems. Has burning inside. Has to urinate often, got up 4x last night, had to rush to toilet. Urine color. No difficulty urinating. No leaking. No fever, chills, nausea or vomiting, abd pain, back or side pain, swelling. No sore flesh or growth on genitals. No pain with sex.

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



Past Health Hx: No operations, diabetes, kidney problems, no freq. UTIs, ⊕ hx. STIs.

LMP: last week - normal
If Pregnant, # weeks: _____

Medicines: Birth control pills.

Allergies: (What & Reaction) None

Immunization status: UTD PPD status: ⊖

Other Hx: No vaginal discharge. Not pregnant. No family hx of kidney problems, ⊕ sex partner with symptoms of STI.

Tobacco: None 2nd-hand Chew Smoke
Thinking about quitting? Y N Already Quit
Never Used Referral: Yes No

Habit Hx: (ETOH, Drugs) No tobacco or alcohol or drugs

EXAM General Appearance: Looks healthy
Vital Signs: T 98.8 P 70 R 14 BP 110/70 SPO2 _____ WT 120 HT _____ HC _____

Head: _____
Eyes: _____ Snellen Test: (R) _____ (L) _____ (B) _____

Ears: (R) _____
(L) _____

Nose/Sinus: _____
Mouth/Throat: _____

Neck/Nodes: _____
Back: ⊖ CVA tenderness

Lungs/Chest: _____
Heart: _____

Breasts: _____
Abdomen: Flat, active bowel sounds. Not tender. No masses.

Genital/Rectal: _____
Extremities: _____

Nervous System: _____
Skin: _____

Lab Tests/Results: Preg test ⊖. Urine dip: yellow, cloudy, pH 6, 2+ leukocytes, + nitrites, 1+ blood, rest negative

ASSESSMENT Bladder infection

Immunizations given:
Initials/Vaccine/Lot #
() _____ # _____
() _____ # _____
() _____ # _____

PLAN Pt. Education: Explained pt. ed. Urinary I, p. 490

Medicines: Trimethoprim/Sulfamethoxazole 80/400. 2 tabs PO 2x day for 3 days.
Phenazopyridine 100mg, 2 PO 3x day for 2 days.

TB Skin Test
() PPD 0.1 ml ID LFA/RFA(circle)
() PPD _____ mm (when read)

Special/Other Care: _____
Recheck/Follow-up: Recheck in 2 days if not better or sooner if worse. Then in 6 days.

Date: 4.1.19.06 Time: 10 AM Doctor: Jones Pract on: 4.1.19.06

Hospital #: _____ SS #: _____ Dr.'s Assessment: _____

Name: (L) John (F) Jane (MI) _____ CHAM Plan Page # 490 Standing Order

DOB: 2.1.22.86 Age: 20 Sex: F Village: Yankin River

Normal Clinic Hrs After Clinic Hrs Home Visit ETOH Related Yes No

COMMUNITY HEALTH AIDE/PRACTITIONER PATIENT ENCOUNTER FORM

Clinic Code _____

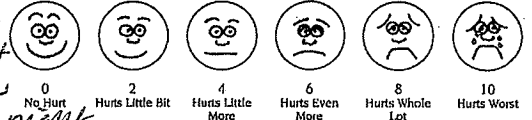
APL	DIS	Initials/Code
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Primary Provider	<input type="checkbox"/>	<input type="checkbox"/>

HISTORY Chief complaint: Earache

Hx of Present Illness: 3 year old with earache for 2 days. Left ear.

Mom thinks it's getting worse. Hurts all the time. Nothing helps or makes it worse. Mom gave Tylenol 3 chewable tabs last night - helped a little. Last ear infection 8 mo. ago, treated with med + got better. No drainage. Tired, won't play. Fever 101° F last night.

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



(+) running nose. No sore throat or cough. No chest pain, SOB, vomiting or diarrhea. Has not been swimming, has not put anything in the ear. Has been rubbing ear. Won't eat, drinks ok.

Past Health Hx: No AOM infections. Not around loud noises. No ear surgery. No chronic problems

LMP: _____
If Pregnant, # weeks: _____

Medicines: Tylenol only

Allergies: (What & Reaction) None

Immunization status: UTD PPD status: Never had TB test

Other Hx: peeing ok. Hears OK, talks OK. Uses words OK.

Tobacco: None (2nd-hand) Chew (Smoke)
Thinking about quitting? Y N Already Quit
Never Used Referral: Yes No

Habit Hx: (ETOH, Drugs) Dad smokes at home; no alcohol in home.

EXAM General Appearance: looks tired

Vital Signs: T 101.4 P 108 R 30 BP 80/58 SPO2 _____ WT 40 lb. HT _____ HC _____

Head: _____ Snellen Test: (R) _____ (L) _____ (B) _____

Ears: (R) outer ear normal, no nodes or mastoid tenderness. Canal pink, no drainage. TM gray, clear, flat, moves well.
(L) outer ear normal, no nodes or mastoid tenderness. Canal pink, no drainage. TM red, cloudy; bulging, not mobile.

Nose/Sinus: clear mucus, no flaring

Mouth/Throat: slightly red, tonsils small, no white patches.

Neck/Nodes: nodes (+) swollen, tender, movable.

Back: _____
Lungs/Chest: No retractions. Sounds clear bilateral. HEARING: hears whisper at 4' (R), 2' (L)

Heart: _____

Breasts: _____

Abdomen: _____

Genital/Rectal: _____

Extremities: _____

Nervous System: _____

Skin: _____

Lab Tests/Results: _____

ASSESSMENT Acute Otitis Media, left

Immunizations given:
Initials/Vaccine/Lot #
() _____ # _____
() _____ # _____
() _____ # _____
TB Skin Test
() PPD 0.1 ml ID LFA/RFA(circle)
() PPD _____ mm (when read)

PLAN Pt. Education: Explained pt. ed, Ear 3, p. 241

Medicines: Amoxicillin 250mg/5ml, 15.5ml (775mg) PO BID x 10 days.
Keep taking Tylenol as needed for fever or pain.

Special/Other Care: _____

Recheck/Follow-up: In 3 days if still has fever > 101° F. then 1 month after

Date: 4/19/06 Time: 9 AM Doctor: antibiotics completed. Jones on: 4/1/06

Hospital #: _____ SS #: _____ Dr.'s Assessment: _____

Name: (L) Smith (F) John Jr. (MI) _____ CHAM Plan Page # 240 Standing Order

DOB: 1/20/03 Age: 3 Sex: M CHA/CHP: Mary Baker CMA IV Village: Yukon River

Normal Clinic Hrs After Clinic Hrs Home Visit

ETOH Related Yes No

COMMUNITY HEALTH AIDE/PRACTITIONER PATIENT ENCOUNTER FORM

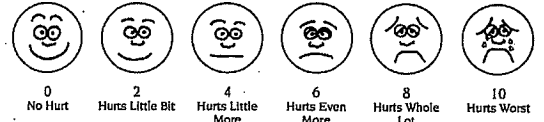
Clinic Code _____

APL	DIS	Initials/Code

Primary Provider

HISTORY Chief complaint: Thinks she has a urine infection
Hx of Present Illness: _____

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



Past Health Hx: _____

LMP: _____

If Pregnant, # weeks: _____

Medicines: _____

Allergies: (What & Reaction) _____ Immunization status: _____ PPD status: _____

Other Hx: _____

Tobacco: None 2nd-hand Chew Smoke
Thinking about quitting? Y N Already Quit
Never Used **Referral:** Yes No

Habit Hx: (ETOH, Drugs) _____

EXAM General Appearance: looks okay

Vital Signs: T _____ P _____ R _____ BP _____ SPO2 _____ WT _____ HT _____ HC _____

Head: _____

Eyes: _____ Snellen Test: (R) _____ (L) _____ (B) _____

Ears: (R) _____
(L) _____

Nose/Sinus: _____

Mouth/Throat: _____

Neck/Nodes: _____

Back: _____

Lungs/Chest: _____

Heart: _____

Breasts: _____

Abdomen: _____

Genital/Rectal: _____

Extremities: _____

Nervous System: _____

Skin: _____

Lab Tests/Results: Urine dip: 1+ leukocytes 1+ blood

ASSESSMENT UTI

Immunizations given:

Initials/Vaccine/Lot #

() _____ # _____

() _____ # _____

() _____ # _____

TB Skin Test

() PPD 0.1 ml ID LFA/RFA(circle)

() PPD _____ mm (when read)

PLAN Pt. Education: _____

Medicines: Trimethoprim/Sulfamethoxazole 2 tabs 2 times a day for 3 days

Special/Other Care: _____

Recheck/Follow-up: if not better

Date: 4/19/06 Time: 10 AM

Doctor: Fixed on: 4/19/06

Hospital #: _____ SS #: _____

Dr.'s Assessment: _____

CHAM Plan Page # _____ Standing Order

Name: (L) Jhm (F) Jane (MI) _____

CHA/CHP: Mary Barber CMAA

DOB: 2/22/86 Age: 20 Sex: F

Village: Yulem River

Normal Clinic Hrs After Clinic Hrs Home Visit

ETOH Related Yes No