A-663 (ANC)
rev. 5/05

Medicaid: ☐ AU ☐ AY

	APL	DIS	Initials/Code
Primary Provider			

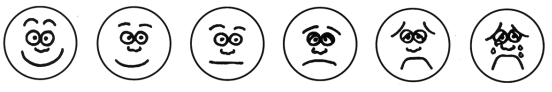
COMMUNITY HEALTH AIDE/PRACTITIONER PATIENT ENCOUNTER FORM

Clinic Code _____

HISTORY Chief complaint: _____

Hx of Present Illness: _____

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



0 No Hurt | 2 Hurts Little Bit | 4 Hurts Little More | 6 Hurts Even More | 8 Hurts Whole Lot | 10 Hurts Worst

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: _____

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: _____

ASSESSMENT _____

PLAN Pt. Education: _____

Medicines: _____

Special/Other Care: _____

Recheck/Follow-up: _____

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

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

Date: ...../...../..... Time: .....

Hospital #:..... SS #: .....

Name: (L)..... (F)..... (MI) .....

DOB:...../...../..... Age: ..... Sex: .....

Doctor: _____ on: ___ / ____ / ____

Dr.'s Assessment: _____

CHAM Plan Page # _____ Standing Order ☐

CHA/CHP: _____

Village: _____

Normal Clinic Hrs ☐ After Clinic Hrs ☐ Home Visit ☐

ETOH Related Yes ☐ No ☐