

# COMMUNITY HEALTH AIDE/PRACTITIONER PATIENT ENCOUNTER FORM

APL	DIS	Initials/Code

Clinic Code \_\_\_\_\_

Primary Provider

**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

Immunizations given:

Initials/Vaccine/Lot #

( ) \_\_\_\_\_ # \_\_\_\_\_

( ) \_\_\_\_\_ # \_\_\_\_\_

( ) \_\_\_\_\_ # \_\_\_\_\_

TB Skin Test

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

( ) PPD 00 mm (when read)

**PLAN** Pt. Education: \_\_\_\_\_

Medicines: \_\_\_\_\_

Special/Other Care: \_\_\_\_\_

Recheck/Follow-up: \_\_\_\_\_

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

Doctor: \_\_\_\_\_ on: \_\_\_ / \_\_\_ / \_\_\_

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

Dr.'s Assessment: \_\_\_\_\_

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

CHAM Plan Page # \_\_\_\_\_ Standing Order

CHA/CHP: \_\_\_\_\_

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

Village: \_\_\_\_\_

Normal Clinic Hrs  After Clinic Hrs  Home Visit

ETOH Related Yes  No