

COMMUNITY HEALTH AIDE/PRACTITIONER PATIENT ENCOUNTER FORM

Clinic Code _____

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

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