

Name _____ DOB: _____

Email Address : _____ Contact Phone Number: _____

TSWF ADULT ENCOUNTER WORKSHEET with SF600 (v20110309)

What is the reason for **today's visit**? _____

How **long** have you had this issue? _____ Please circle if this issue is getting **better** **worse**

Please rate your **pain level** on a scale of 0 (no pain) to 10 (severe pain): # ___/10

Please complete information below: **If you have filled this form out before, please only list changes since last visit.**

Current Medications	Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents) (Circle all that apply)
<p><u>PLEASE INCLUDE DOSAGE. IF YOU HAVE A LIST WITH YOU HAVE IT READY.</u></p> <p>If you take medications, do you always remember to take them? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><i>Do you have any of the following? (circle)</i></p> <p><i>High Blood pressure</i> <i>High Cholesterol</i> <i>Diabetes</i> <i>Asthma</i> <i>Heart Disease</i> <i>Obesity</i> <i>Cancer</i> <i>Had a Heart Attack</i> <i>Other:</i></p> <p>ie: chronic pain, migraines, sleep apnea</p>		<p>HIGH BLOOD PRESSURE:</p> <p>HIGH CHOLESTEROL:</p> <p>DIABETES:</p> <p>CANCER:</p> <p>OTHER:</p> <p>ie: Heart Attack, Stroke</p>

Please check if you take: Vitamins Over the counter meds Dietary Supplements Herbal meds Weight loss meds

Please list any **allergies** you have (drug, food, latex) _____

Yes No Do you consume any alcohol? If yes, Type? _____ frequency? _____ amount? _____

Yes No Do you now or have you ever used **tobacco** products? (If YES, check the box that applies to you)

I CURRENTLY USE TOBACCO PRODUCTS What type of tobacco? _____ How much per day? _____

I QUIT USING TOBACCO PRODUCTS When did you quit? _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

[0] [1] [2] [3]

Little interest or pleasure in doing things Not at all Several days More than half the days Nearly every day

Feeling down, depressed, or hopeless Not at all several days More than half the days Nearly every day

Would you say your general health is? Excellent Very Good Good Fair Poor

Yes No Is this visit **deployment** related? If yes, when and where was deployment _____

Date of last PHA _____

RECORDS MAINTAINED AT: 		
PATIENT'S NAME (Last, First, Middle Initial)		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

Please Complete Back Page

Yes No Do you have any learning disabilities, language barrier, hearing/vision deficit? _____

What is your preferred language? Specify: _____

What is your preferred method for learning: Verbal Written Visual Other: _____

Ethnic Origin Filipino Hispanic Asian/Pacific Islander Southeast Asian Other Unknown Decline to Respond

Race Asian/Pacific Islander African American Caucasian Western Indian Other Unknown Decline to Respond

Yes No Do you feel safe at home?

Yes No Do you have an advanced directive? Yes No Would you like information on Advance Directives

Yes No Do you have any cultural or religious beliefs that may affect your care?

Yes No Are you enrolled in EFMP?

Yes No **Special Duty?** If yes check which applies PRP SCI PSP

Yes No Are you on active flying status?

Preventive Health Questions (If you have filled this out before, please only list changes since last visit):

Have you ever had any of the following?				
Aspirin Prophylaxis.....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know
Colonoscopy/Flex sig (circle one).....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know
Cholesterol screening.....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know
Diabetes screening.....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know
Diet Counseling if at risk.....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know
HIV Screening.....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know
Influenza Vaccine.....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know
Pneumovax (pneumonia vaccine).....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know
Tetanus booster in last 10 yrs?.....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know

Male Specific Screening:				
PSA/Prostate Exam.....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know

Female Specific Screening:				
Are you Sexually Active	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	# of partners in last year _____	
Could you be pregnant	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	Date of Last Period _____	
# of Pregnancies _____	# of Term Deliveries _____	# of Premature Deliveries _____	# of Miscarriages/ Terminations _____	

Have you ever had any of the following?				
Pap Smear.....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know
STD screening.....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know
Postmenopausal	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	If yes, Menopause at Age _____	
Hysterectomy	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	Date of Hysterectomy _____	

Type of Birth Control Used				
<input type="checkbox"/> Withdrawal Method	<input type="checkbox"/> Rhythm Method	<input type="checkbox"/> Diaphragm	<input type="checkbox"/> Condoms	
<input type="checkbox"/> Oral Contraceptives	<input type="checkbox"/> Transdermal Patch	<input type="checkbox"/> Intrauterine Device IUD	<input type="checkbox"/> Subdermal Implant	
<input type="checkbox"/> Intramuscular Inj DEPO	<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Partner had Vasectomy		
Date of Last Mammogram? _____	History of Abnormals?	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	<input type="checkbox"/> Do not know
Calcium Supplementation.....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know
Folic Acid Use.....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know
Bone Density Scan (DEXA).....	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	(when? _____)	<input type="checkbox"/> Do not know

------(This section NOT for patient use)-----

HEALTH	CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE: | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*Sign each entry*)

AHLTA was not accessible during this patient visit. Reviewed note & agree with the reverse side ____ (*Provider Initial*)

VITALS: B/P _____ Pulse _____ RR _____ Temp _____ Ht _____ Wt _____ O2Sat _____ Pain ____/10
LMP _____

SUBJECTIVE:

OBJECTIVE:

ASSESSMENT:

PLAN:

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