

FEMALE ADULT 21 - 49 YEARS				Name: _____				
Visit Date: ___/___/___				DOB: ___/___/___ Age: _____				
Language spoken: <input type="checkbox"/> English Other: _____				<input type="checkbox"/> Interpreter used – Name: _____				
BP:	L	R	T:	P:	R:	Height:	Weight:	BMI:
Reason for visit: _____								
Allergies: _____				Signature/ Title: _____				

INTERVAL HISTORY		EDUCATION / ANTICIPATORY GUIDANCE: <i>Check if discussed</i>	
Diet: _____	Appetite: _____	Diet and exercise	<input type="checkbox"/> food choices/caloric balance <input type="checkbox"/> appropriate weight <input type="checkbox"/> body image <input type="checkbox"/> eating disorders <input type="checkbox"/> physical activity
Weight - significant <input type="checkbox"/> loss <input type="checkbox"/> gain # lbs.: _____		Safety	<input type="checkbox"/> anger management <input type="checkbox"/> domestic violence <input type="checkbox"/> DUI <input type="checkbox"/> seat belt use <input type="checkbox"/> weapons
Physical Activity: _____		High Risk Behaviors	<input type="checkbox"/> smoking <input type="checkbox"/> alcohol, drugs <input type="checkbox"/> sexual activity (condoms, contraception, STD risk)
Seeing dentist: <input type="checkbox"/> Yes <input type="checkbox"/> No TB risk: <input type="checkbox"/> No <input type="checkbox"/> Yes		Guidance	<input type="checkbox"/> daily ASA <input type="checkbox"/> depression <input type="checkbox"/> family communication <input type="checkbox"/> breast self exam <input type="checkbox"/> personal goals <input type="checkbox"/> sun screen
Medications / Vitamins: _____		<input type="checkbox"/> Advance Directives information offered/discussed	
Menarche age: _____ LMP: ___/___/___		Comments: _____	
G: _____ P: _____ Ab: _____ <input type="checkbox"/> breastfeeding history			
Sexually active: <input type="checkbox"/> No <input type="checkbox"/> Yes – contraception type: _____			
Tobacco - <input type="checkbox"/> smoke exposure <input type="checkbox"/> use			
Alcohol: <input type="checkbox"/> No <input type="checkbox"/> Yes			
Drugs: <input type="checkbox"/> No <input type="checkbox"/> Yes			

IMMUNIZATIONS - year: Last Td: _____ MMR: _____ Varicella or chicken pox: _____

Illnesses, accidents, headaches, fatigue, depression: _____

PATIENT CONCERNS: _____

PHYSICAL EXAMINATION – *note required for all not WNL*

General Appearance	<input type="checkbox"/> well nourished and developed <input type="checkbox"/> no abuse/neglect evident	Heart	<input type="checkbox"/> regular rhythm <input type="checkbox"/> no murmur
Head	<input type="checkbox"/> grossly normal	Femoral pulses	<input type="checkbox"/> normal bilaterally
Eyes	<input type="checkbox"/> PERRL <input type="checkbox"/> vision grossly normal	Abdomen	<input type="checkbox"/> soft, no masses <input type="checkbox"/> liver & spleen normal
Ears	<input type="checkbox"/> canals clear <input type="checkbox"/> TMs normal <input type="checkbox"/> hearing grossly normal	Genitalia	<input type="checkbox"/> grossly normal
Nose	<input type="checkbox"/> passages clear <input type="checkbox"/> MM pink, no lesions	<i>Pap/Chlamydia</i>	<input type="checkbox"/> not indicated <input type="checkbox"/> done <input type="checkbox"/> referral made
Teeth	<input type="checkbox"/> good dentition <input type="checkbox"/> no caries evident	Rectal	<input type="checkbox"/> normal Occult blood - <input type="checkbox"/> no <input type="checkbox"/> yes
Neck	<input type="checkbox"/> supple <input type="checkbox"/> thyroid not enlarged	Spine	<input type="checkbox"/> no scoliosis
Chest/Breasts	<input type="checkbox"/> symmetrical <input type="checkbox"/> no masses	Extremities	<input type="checkbox"/> no deformities, full ROM
Lungs	<input type="checkbox"/> clear to auscultation bilaterally	Skin	<input type="checkbox"/> clear, no significant lesions
		Neurologic	<input type="checkbox"/> no gross sensory or motor deficit

ASSESSMENT: <i>Repeat BP if > 140/90</i>	PLAN:

ORDERS: Vaccine reactions, risks and follow-up explained /VIS sheets given

Immunizations (if indicated / not up to date)

MMR Varicella Td Influenza vaccine

HPV (up to age 26) Pneumovax (if high risk)

Diagnostic Testing (if indicated/at risk)

Lipid profile (q 5 years > 45 or at risk) HbA1c

HIV test U/A PPD

Screening

Nutritional assessment

Mammogram (every 1 to 2 years beginning at age 40)

Pap Chlamydia (up to age 25 or if indicated)

Prevention ASA 81mg qd

Rx. For Folic Acid 0.4 mg daily (if childbearing age)

Other: _____

REFERRAL: Dental Drug/ETOH Rehab Smoking cessation OB/Gyn Mental Health **Other:** _____

Next appointment: 1 year or _____ **Provider Signature:** _____