Initial Encounter worksheet, MRC v20120801

Patient Name: Rank: SSN last four:

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

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

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

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

E. Current Medications	F. Medical Conditions	G. Surgeries/Hospitalizations (Dates)	H. Family History
PLEASE INCLUDE DOSAGE. IF YOU HAVE A LIST WITH YOU HAVE IT READY. (Include over-the-counter meds, Tylenol, vitamins, herbal supplements): If you take medications, do you always remember to take them? ❑ Yes ❑ No	***Do you have any of the following? (circle)*** ***High Blood pressure*** ***High Cholesterol*** ***Diabetes*** ***Asthma*** ***Heart Disease*** ***Obesity*** ***Cancer*** ***Had a Heart Attack*** ***Other:***		***HIGH BLOOD PRESSURE:*** ***HIGH CHOLESTEROL:*** ***DIABETES:*** ***CANCER:*** ***OTHER:***

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

J. Please list any **allergies** you have (drug, food, latex) _____ ❑ No Allergies

K. ❑Yes ❑No Do you consume any alcohol? If yes, Type? _____frequency? _____ amount?_____

❑Yes ❑Never Do you now or have you ever used **tobacco** products, including chew? (If YES, check the box that applies)

❑ I CURRENTLY USE Tobacco Products What type of tobacco? _____ How much per day? _____

❑ I QUIT USING Tobacco Products When did you quit?_____

L. 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

Female Questions: ❑Yes ❑No Could you be pregnant? Date of Last Period _____ ❑Unknown

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

❑Yes ❑No Do you feel safe at home?

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

❑Yes ❑No Are you currently Active Duty? If yes, have you had a PHA in the last year?_____

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

❑Yes ❑No Do you have any learning disabilities? _____

❑Yes ❑No Do you have an advanced directive?

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

❑Yes ❑No Are you enrolled in EFMP?

Please provide a good contact telephone number: _____

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

❑Yes ❑No Are you on active flying status? ❑Yes ❑No Are you on Space and Missile Operations Duty (SMOD)?

(COMPLETE THE REVERSE SIDE)

Preventive Health Questions :

Have you ever had any of the following?				
Aspirin Prophylaxis……..	□ **NO**	□ Yes	(when?_____)	□ Do not know
Colonoscopy/Flex sig (circle one)…….	□ **NO**	□ Yes	(when?_____)	□ Do not know
Cholesterol screening……	□ **NO**	□ Yes	(when?_____)	□ Do not know
Diabetes screening……..	□ **NO**	□ Yes	(when?_____)	□ Do not know
Diet Counseling if at risk…….	□ **NO**	□ Yes	(when?_____)	□ Do not know
HIV Screening…….	□ **NO**	□ Yes	(when?_____)	□ Do not know
Influenza Vaccine…….	□ **NO**	□ Yes	(when?_____)	□ Do not know
Pneumovax (pneumonia vaccine)……..	□ **NO**	□ Yes	(when?_____)	□ Do not know
Tetanus booster in last 10 yrs?.....	□ **NO**	□ Yes	(when?_____)	□ Do not know
Female Specific Screening:				
Date of Last Mammogram?_____	History of Abnormals? □ **NO** □ Yes			
Pap Smear…….	□ **NO**	□ Yes	(when?_____)	□ Do not know
Chlamydia screening……..	□ **NO**	□ Yes	(when?_____)	□ Do not know
Calcium Supplementation……..	□ **NO**	□ Yes	(when?_____)	□ Do not know
Folic Acid Use……..	□ **NO**	□ Yes	(when?_____)	□ Do not know
Bone Density Scan (DEXA)……..	□ **NO**	□ Yes	(when?_____)	□ Do not know
Male Specific Screening:				
PSA/Prostate Exam……..	□ **NO**	□ Yes	(when?_____)	□ Do not know

For Office Staff Use Only:

VS: T_____ BP_____ HR _____ RR _____ O2 sat _____

Ht _____ Wt _____ VA OD 20/_____ OS 20/_____