ADULT/ADOLESCENT ASSESSMENT FORM

Date:______________ File#:______________ Name:________________________________ DOB:____________________

HOH:________________________________ Temp:_______ Pulse:_____ Resp. Rate:_____ B.P. Right:_____ Left:_____ Height:_______

Weight:________ Frame size: S___ M___ L____ Ideal Weight:__________ Obese:________ WNL:____________ Thin______________

Visual Acuity: (R) OD:____ (L) OS:____ OU____ (Check if with corrective lenses):__________ SITE NAME/NUMBER____________________

	N	A	Not Done	Comments
Skin, Hair	__	__	________	____________
Adenopathy	__	__	________	____________
Eyes	__	__	________	____________
Fundi	__	__	________	____________
ENT	__	__	________	____________
Teeth, Gums	__	__	________	____________
Class I II III	__	__	________	____________
Neck, Thyroid	__	__	________	____________
Breast self exam taught? Yes/No	__	__	________	____________
Chest	__	__	________	____________
Heart	__	__	________	____________
Abdomen	__	__	________	____________
Genitalia, Pelvic	__	__	________	____________
Rectal	__	__	________	____________
Stool Hematest	__	__	________	____________
Prostate	__	__	________	____________
Extremities	__	__	________	____________
Peripheral pulses	__	__	________	____________
Neurologic:DTs	__	__	________	____________
Neurologic:other	__	__	________	____________
Mental Status	__	__	________	____________

Assessment/ Plan:

Vaccines Administered today:

Type:_______ Dose:_________ Location:________

Venipuncture test:________________ Location:____________

Are Immunes Current: Y___ N___

PPD planted:_____________ Arm:__________________

Laboratory:

BS:__________ FBS:____________ Hct:____________

Health Education:

Nutrition: HTN:___ Diabetes:___ Obesity:___ Exercise:___
STD___ HIV___ Other___

Substance Abuse: Alcohol___ Tobacco___ Other___

Women's Health: Mammogram:___ Pap:____________

Cancer: Breast___ Oral___ Cervix___ Skin___
Colorectal:____ Testicular:____

Referrals: MD___ Date/Voucher____________ DDS___ Date/Voucher____________ Rx Only___ Date/Voucher____________

WIC____ Date____________ Other___ Date/List____

Family Planning: On-Site___ Off-Site______

On-Site: Family Planning Method________________

Counseling of patient before/at time patient received family planning method: Check as completed

___a) Method selected by patient

___b) Discussion of efficiency, use, side effects

___c) Discussion of full range of alternative methods

___d) Discussion of prevention of HIV and STD infection

___e) Counseling/ testing for HIV, as appropiate

___f) Return visit scheduled

Clinician's Signature:____