TSWF-Core Encounter with SF600-Intake (New) v20130320

Patient Name: | Rank: (Active Duty Only) | FMP and Sponsor 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**

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. 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: (type, who, and what age when diagnosed?)*** ***HEART ATTACK: (who, age?)*** ***STROKE:***

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?

❑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? _____ How much per day? _____Interested in quitting? ❑Yes ❑No

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

❑Yes ❑No Do you do moderate exercise for at least 30 minutes most days a week? (Activity that raises heart rate/causes sweat)

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

Females Only: Could you be pregnant? ❑Yes ❑No Date of Last Period _____ ❑Unknown ❑Had a hysterectomy

M. How would you say your general overall feeling is? ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

❑Yes ❑No Do you feel safe at home?

❑Yes ❑No Have you had any hospitalizations, specialty care, or ER visits since your last appointment?

If yes, please tell us where you were seen and why?_____

_____

N. What is your preferred language? _____

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

❑Yes ❑No Do you have a learning disability, language barrier, hearing/vision deficit?_____

❑Yes ❑No Do you have an advance directive? If yes, have you given a copy to your Primary Provider? ❑Yes ❑No

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

❑Yes ❑No Are you enrolled in EFMP (Exceptional Family Member Program)?

❑Yes ❑No Enrolled in ***RelayHealth/Secure Messaging***? **E-mail address** if no:_____

Please provide a good contact **telephone number**:_____

General Screening:			
Have you had your Cholesterol checked?	☐ **NO**	☐ Yes, when was the last test? _____	☐ Do not know
Have you been tested for Diabetes?	☐ **NO**	☐ Yes, when was the last test? _____	☐ Do not know
If you are a diabetic, when was your last HbA1c?	☐ **NO**	☐ Yes, when was the last test? _____	☐ Not diabetic
Do you take a daily Aspirin for cardiovascular protection?	☐ **NO**	☐ Yes	
Have you been tested for HIV?	☐ **NO**	☐ Yes, when was the last test? _____	
Have you had Colon Cancer screening? (eg. Colonoscopy) *Recommended after age 50*	☐ **NO**	☐ Yes, when was the last test? _____	

Immunization status:			
Have you had your Tetanus booster in the last 10 yrs?	☐ **NO**	☐ Yes, when was the vaccine given?_____	☐ Do not know
Have you had your Annual Influenza Vaccine (Flu)?	☐ **NO**	☐ Yes, when was the vaccine given?_____	☐ Do not know
Have you had your Shingles vaccine? *Recommended after age 60*	☐ **NO**	☐ Yes, when was the vaccine given?_____	☐ Do not know
Have you had your Pneumonia vaccine? *Recommended after age 65 and younger people at increase risk of pneumonia*	☐ **NO**	☐ Yes, when was the vaccine given?_____	☐ Do not know
Have you had your HPV vaccine series? *Recommended before age 26*	☐ **NO**	☐ Yes, when was the vaccine series completed?_____	☐ Do not know

Female Specific Screening:			
Have you had Cervical Cancer screening (Pap Smear)?	☐ **NO**	☐ Yes, when was the last Pap smear? _____	☐ Do not know ☐ Had a hysterectomy
Date of Last Mammogram?_____	History of Abnormal Mammograms? ☐ NO ☐ **Yes**		
Have you been tested for Chlamydia? *Recommended for women ≥65 yrs or younger women at increased risk of osteoporosis*	☐ **NO**	☐ Yes, when was your last test? _____	☐ Do not know
Have you had a Bone Density Scan (DEXA)? *Recommended for women ≥65 yrs or younger women at increased risk of osteoporosis*	☐ **NO**	☐ Yes, when was your last DEXA? _____	
Do you take Folic Acid daily? *Recommended for women of childbearing age to prevent birth defects*	☐ **NO**	☐ Yes	

Male Specific Screening:			
If you have EVER been a smoker and are age 65-75, you should be screened for an abdominal aneurysm. Have you had this screening?	☐ **NO**	☐ Yes, when was the test done?_____	☐ Non-Smoker ☐ <65 years old

VITALS: B/P _____ Pulse _____ RR _____ Temp _____ Ht _____ Wt _____ O2Sat _____