TSWF-Core Encounter Worksheet with SF600 v3Q2013

Patient Name: _____ **Rank(AD Only)** _____ **DOB** _____ **FMP/Sponsor SSN last four:** _____

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

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

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

C. With regard to pain, please indicate the following: Location:_____ Duration: _____

Describe: (sharp, dull, travels throbbing etc):_____

D. Factors that correlate with onset(What caused it)_____ Frequency:_____

Average level of pain:_____ Worst level: _____ Least level: _____

What makes it better:_____ What makes it worse:_____

E. Medical Conditions	**H. Allergies**	**K. Preventive Services: Please indicate the date these services were completed:**
Do you have any of the following? (circle) **High Blood pressure - High Cholesterol** **Diabetes - Asthma - Heart Disease** **Obesity - Cancer - Had a Heart Attack** **Other:**	(drug, food or latex)	**Lipid Screening -** **Diabetes Screening -** **Aspirin Prophylaxis** ❑ Yes ❑ No **HIV Screen -** **Colonoscopy -** **Tetanus (Td/Tdap) -** **Influenza Vaccine -** **Zoster Vaccine -** **Pneumococcal Vaccine -** **HPV Vaccine -** **Women:** **Cervical Cancer Screen - Pap:** **HPV:** **Mammogram -** **Chlamydia Screen -** **Osteoporosis Screen -** **Folic Acid -** ❑ Yes ❑ No **Men:** **Aortic Aneurysm Screen -**
F. Surgeries or Hospitalizations (dates)	**I. Current Medications**	
	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	
G. Family History (biological siblings, parents, grandparents) (Circle all that apply	**J. Social History**	
HIGH BLOOD PRESSURE: ***HIGH CHOLESTEROL:*** ***DIABETES:*** ***HEART ATTACK: (who, age?)*** ***CANCER: (type, who, and what age when diagnosed?)*** ***OTHER:***	Family/Occupation issues:	

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 Have you travelled outside the country in the last 90 days? Where_____

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

❑Yes ❑No Do you consume any alcohol? If yest, Type?_____ Frequency?_____ Amount?_____

❑Yes ❑Never Do you now or have you ever used **tobacco** products, including chew? If YES, check the following 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?_____

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

❑Yes ❑No Do you feel unsafe in your personal relationships?

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

❑Yes ❑No Since your last visit with us, have you had any medical care other than in this clinic?

❑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? ❑Yes ❑No Date of PHA:_____
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
If 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 (Exceptional Family Member Program)?

❑Yes ❑No Enrolled in ***Relay Health/Secure Messaging***? Please give us your **E-mail address**:_____

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

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

Female Specific Screening:				
Are you Sexually Active		□ **NO**	□ Yes	**# of partners in last year** _____
Could you be pregnant		□ **NO**	□ Yes	**Date of Last Period** _____
# of Pregnancies _____	# of Term Deliveries _____	# of Premature Deliveries _____		# of Miscarriages/ Terminations _____
Have you ever had any of the following?				
Postmenopausal		□ **NO**	□ Yes	If yes, Menopause at Age_____
Hysterectomy		□ **NO**	□ Yes	**Date of Hysterectomy** _____
Type of Birth Control Used				
□ Withdrawal Method	□ Rhythm Method	□ Diaphragm		□ Condoms
□ Oral Contraceptives	□ Transdermal Patch	□ Intrauterine Device IUD		□ Subdermal Implant
□ Intramuscular Inj DEPO	□ Tubal Ligation	□ Partner had Vasectomy		
Calcium Supplementation……..		□ **NO**	□ Yes	(when?_____) □ Do not know