

TSWF ENCOUNTER WORKSHEET with Prevention (v20101214)

Name: Violet Alexander

Date: 10-18-11

What is the reason for today's visit? Refill of Blood pressure med

How long have you had this issue?

Is this issue getting better or worse?

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

BP 115/71
Ht 60 in
Wt 105 lbs

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

Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History	Current Medications
<p>Do you have any of the following? (circle)</p> <p>High Blood pressure</p> <p>High Cholesterol</p> <p>Diabetes</p> <p>Asthma</p> <p>Heart Disease</p> <p>Obesity</p> <p>Cancer</p> <p>Had a Heart Attack</p> <p>Other:</p>		<p>HIGH BLOOD PRESSURE:</p> <p>HIGH CHOLESTEROL:</p> <p>DIABETES:</p> <p>CANCER:</p> <p>OTHER:</p>	<p>PLEASE INCLUDE DOSAGE. IF YOU HAVE A LIST WITH YOU HAVE IT READY.</p> <p><u>HCTZ 12.5mg daily</u></p>

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

Please list any allergies you have (drug, food, latex) none

Yes No Do you consume any alcohol? If yes, Type? _____ frequency? _____ amount? _____

Yes No Do you now or have you ever used tobacco products? (If YES, check the box that applies to you)

I CURRENTLY USE TOBACCO PRODUCTS What type of tobacco? _____ How much per day? _____

I QUIT USING TOBACCO PRODUCTS When did you quit? 10-12-10

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 8-1-11

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

Yes No Do you have any learning disabilities? _____

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

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

Yes No Do you feel safe at home?

Yes No Do you have an advanced directive?

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

Yes No Are you on active flying status?

(ADDITIONAL QUESTIONS ON REVERSE SIDE)