TSWF ENCOUNTER WORKSHEET with Prevention (v20101214)

Name: Violet Alexander **Date:** 8-12-10

What is the reason for **today's visit?** Refill of Motrin for kneepain

How **long** have you had this issue? 2 yrs

Is this issue getting **better or worse**? worse

Please rate your **pain level** on a scale of 0 (no pain) to 10 (severe pain): # 4/10

BP 160/95
HR 80
RR 15
Ht 60 in
Wt 240 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
Do you have any of the following? (circle) ***High Blood pressure*** ***High Cholesterol*** ***Diabetes*** ***Asthma*** ***Heart Disease*** ***Obesity*** ***Cancer*** ***Had a Heart Attack*** ***Other:***	Tonsils age 8	***HIGH BLOOD PRESSURE:*** Father ***HIGH CHOLESTEROL:*** ***DIABETES:*** Mother ***CANCER:*** ***OTHER:***	**PLEASE INCLUDE DOSAGE. IF YOU HAVE A LIST WITH YOU HAVE IT READY.** Motrin 400mg 3 times a day

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

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? Ciggs How much per day? 2 packs a day

☐ 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

Female Questions: ☐Yes ☑No Could you be pregnant? Date of Last Period 8-1-10

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)