

**TSWF ENCOUNTER WORKSHEET with Prevention (v20101214)**

Name: Violet Alexander

Date: 9-12-10

What is the reason for today's visit? Blood Pressure up

Home BPs

How long have you had this issue? 1 Month

165/92

Is this issue getting better or worse? worse

155/87

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

168/93

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><b>Do you have any of the following? (circle)</b></p> <p><b>High Blood pressure</b></p> <p><b>High Cholesterol</b></p> <p><b>Diabetes</b></p> <p><b>Asthma</b></p> <p><b>Heart Disease</b></p> <p><b>Obesity</b></p> <p><b>Cancer</b></p> <p><b>Had a Heart Attack</b></p> <p><b>Other:</b></p>		<p><b>HIGH BLOOD PRESSURE:</b></p> <p><b>HIGH CHOLESTEROL:</b></p> <p><b>DIABETES:</b></p> <p><b>CANCER:</b></p> <p><b>OTHER:</b></p>	<p><b>PLEASE INCLUDE DOSAGE. IF YOU HAVE A LIST WITH YOU HAVE IT READY.</b></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? 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 9-1-10

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)**