A-663 (ANC)
rev. 12.2021

Medicaid: ☐ AU ☐ AY

	APL	DIS	Initials/Code			
Primary Provider						

COMMUNITY HEALTH AIDE/PRACTITIONER PATIENT ENCOUNTER FORM

Clinic Code _____

HISTORY: Chief complaint: _____

Infectious Disease Screen: _____

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL

COVID Vaccine: Y N Which one: _____ Number of doses: _____ Date of last shot: _____
Tested POSITIVE for COVID: Y N When: _____

HPI: _____

Illnesses: _____
Hospitalizations: _____
Past Surgeries: _____

Medicines: _____

Allergies: _____ Reaction: _____

Tobacco: None Chew Smoke Vape
How much: _____
How long: _____
Thinking about quitting? Y N Referral: Y N
Smokers in home? Y N

Alcohol: Y N What: _____
How much: _____
How often: _____
Last Use: _____
Alcohol use in the home: Y N

Marijuana: Y N What: _____
How much: _____
How often: _____
Last Use: _____
Marijuana use in the home: Y N

Drugs: Y N What: _____
How much: _____
How often: _____
Last Use: _____
Drug use in the home: Y N

Last TB skin test: _____ Pos Neg
History + test or TB: Y N
When: _____
Treated: Y N How long: _____

Immunizations UTD: Y N Unsure
Flu shot this season: Y N

High Risk Health Conditions: Y N
List: _____

LMP: _____ Normal: Y N Think might be pregnant: Y N Birth Control: Y N What: _____
Trying to get pregnant: Y N Want information about birth control: Y N Breastfeeding: Y N
Been pregnant or delivered a baby in last 6 weeks: Y N

Name: (L) _____ (F) _____ DOB: ____ / ____ / ____

CHA/P PATIENT ENCOUNTER FORM PAGE 2 OF 2

EXAM: General Appearance_____

VS: T _____º P_____ R____ BP_____/_____ SPO2____% WT _____kg change: _____ HT _____cm HC _____ cm

Head:_____

Eyes: _____ Snellen Test: RT___/___ LT ___/___ B ___/___

Ears: R)_____

(L)_____

Nose/Sinus: _____

Mouth/Throat:_____

Neck/Nodes: _____

Back: _____

Lungs/Chest: _____

Heart :_____

Breasts: _____

Abdomen: _____

Genital/Rectal:_____

Extremities: _____

Nervous System: _____

Skin: _____

Lab tests/results: _____

Immunizations given: Vaccine / Lot # / initials

_____ / # _____ / (___) _____ / # _____ / (___)

_____ / # _____ / (___) _____ / # _____ / (___)

_____ / # _____ / (___) _____ / # _____ / (___)

TB skin test:

( ) PPD 0.1mL given ID RFA LFA

PPD read: ____ / ____ / ____

_____ mm

ASSESSMENT: _____

_____

PLAN (number): _____

_____

Patient Education: _____

_____

_____

Medicines: _____

_____

_____

Special/Other Care: _____

_____

_____

Recheck/Follow up: _____

Documentation Continued: _____

_____

_____

_____

_____

Name: (L) _____ (F) _____ DOB: ____ / ____ / ____ Age: _____ Gender: M F Other

CHA/P: _____ Village: _____ Date: ____ / ____ / ____

Provider: _____ Provider's Assessment: _____

Normal Clinic Hours: Y N After Clinic Hours: Y N ETOH Related: Y N

(CONTINUATION) CHA/P PATIENT ENCOUNTER FORM

Date: ____/____/_____ Time:_____
Name(L)_____ (F)_____
DOB:____/____/_____ Age____ Sex____

Standing Order □_____
Village: _____
CHA/CHP:_____