A-663 (ANC)
rev. 11/2023

COMMUNITY HEALTH AIDE/PRACTITIONER PATIENT ENCOUNTER FORM

Clinic Code _____

HISTORY: Chief complaint: _____

HPI: _____

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL

Illnesses: _____

Hospitalizations: _____

Past Surgeries: _____

Medicines: _____

Allergies: Y N

To what: _____ Reaction: _____

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: _____

(less than 8 years) Alcohol use in the home: Y N

Marijuana: Y N What: _____

How much: _____

How often: _____

Last Use: _____

(less than 8 years) Marijuana use in the home: Y N

Drugs: Y N What: _____

How much: _____

How often: _____

Last Use: _____

(Less than 8 years) 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

If no, would you like one today? Y N

High Risk Health Conditions: Y N

List: _____

LMP: _____ Normal: Y N Breastfeeding? Y N Do you think you might be pregnant? Y N

Do you use birth control? Y N If yes, what: _____

If no, are you trying to get pregnant or would you like more information about birth control? Y N

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

CHA/P PATIENT ENCOUNTER FORM PAGE 2 OF 2

EXAM: General Appearance_____

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

Head/Sinus:_____

Eyes: _____Snellen Test: (R)___/___ (L) ___/___ (B)___/____

Ears:(R)_____

(L)_____

Nose: _____

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 and title): _____

Standing Orders Used: Y N

Patient/Medicine Education: _____

_____

_____

Medicines: _____

_____

_____

Special/Other Care: _____

_____

_____

Recheck/Follow up: _____

Documentation Continued: _____

_____

_____

_____

_____

Name: (L) _____ (F) _____ DOB ___ / ___ / ___ MRN _____ Gender: M F Other

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

Referral 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:_____