TSWF ENCOUNTER WORKSHEET v20110614

Patient Name: Rank: (Active Duty Only):

What is the **MAIN REASON** for today's visit with your provider (list one thing)?

1._____

How **long** have you had this issue? _____ Please check if this issue getting ❑**better** ❑**worse**

If there is time during the visit, list **TWO OTHER THINGS** you want to talk about:

1._____

2._____

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: Who?	Current Medications
Do you have any of the following? (Check) ❑High Blood pressure ❑High Cholesterol ❑Diabetes ❑Asthma ❑Heart Disease ❑Obesity ❑Cancer ❑Had a Heart Attack ❑Other:		❑ HIGH BLOOD PRESSURE: ❑HIGH CHOLESTEROL: ❑DIABETES: ❑CANCER: ❑OTHER:	**PLEASE INCLUDE DOSAGE. IF YOU HAVE A LIST WITH YOU HAVE IT READY.** (Include over-the-counter meds, Tylenol, vitamins, herbal supplements): If you take medications, do you always remember to take them? ❑Yes ❑No

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) _____ ❑ No Allergies

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

❑Yes ❑Never Do you now or have you ever used **tobacco** products, including chew? (If YES, check the box that applies)

❑ I CURRENTLY USE Tobacco Products What type of tobacco? _____ How much per 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

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

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

❑Yes ❑No Do you have any learning disabilities? _____

❑Yes ❑No Do you feel safe at home?

❑Yes ❑No Do you have an advanced directive?

❑Yes ❑No Do you have any cultural or religious beliefs that may affect your care?

❑Yes ❑No Are you enrolled in EFMP?

❑Yes ❑No Do you use a Personal Health Record (PHR)?

❑Yes ❑No Please provide a good contact telephone number: _____

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

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

❑Yes ❑No Are you on active flying status? ❑Yes ❑No Are you on Space and Missile Operations Duty (SMOD)?

Female Questions: ❑Yes ❑No Could you be pregnant? Date of Last Period _____ ❑Unknown

Date Last Pap? _____ ❑N/A ❑Normal ❑Abnormal ❑Postmenopausal Menopause at Age_____

❑Yes ❑No Hysterectomy? Date:_____ Type of Birth Control Used_____