

**AUM NURSING CARE CENTER
PROBLEM VISIT RECORD**

DATE: 2/17/11 TIME: 10:00 PT. HISTORY REVIEWED / UPDATED 1 / 1

PATIENT NAME: Kenley Obas DOB: _____ AGE: _____

PRESENT COMPLAINT: Pt travelling to China. Needing to complete Hep A vaccine and to take typhoid. pm

MEDICATIONS:						LMP:
Temp	Pulse	Resp	B/P	HT	WT	Allergies
						<u>NKMA</u>

INITIAL VISIT		RETURN VISIT
Skin		
Sinuses		
Ears	Reviewed instructions for oral typhoid vaccine. Pt received instruction sheet, brochure and reminder sticker. Pt verbalized understanding.	
Eyes		
Nose		
Throat		
Neck/ Back		
Heart		
Lungs		
Abdomen		
GU/GI		
Extremities		

DIAGNOSIS:	TESTS	RESULTS

PLAN: _____

CALL BACK: _____

PRACTITIONER SIGNATURE: _____ STAFF SIGNATURE: [Signature]

AUDIT DATE: _____ COMMENTS: _____

PHYSICIAN SIGNATURE: _____

AUM NURSING CARE CENTER
ADOLESCENT/ADULT HEALTH HISTORY

Date 6/26/08

Name Kenley Davis

1. What is the reason for your visit today? Vaccine
2. Is there anything about you and your health that we need to know? NO
- *3. List medicine, drugs, or food you are allergic to: None
- *4. List any medicines or drugs you take: None
5. Have YOU or anyone in your family had any of the following: (circle)

heart disease
high blood pressure
stroke

diabetes/sugar
blood problem or disease
cancer

tuberculosis
birth defects
mental retardation

nerve or mental problems
asthma
died before age 50
other "family" disease

6. Have you ever been in the hospital? NO Why? _____
7. Have you ever had surgery? NO Why? _____
8. Have you ever had a serious accident? None
9. Have you had serious or recent problems with:

ears or throat	<u>NO</u> YES	cough	<u>NO</u> YES	kidneys	<u>NO</u> YES	gallbladder	<u>NO</u> YES
allergies	<u>NO</u> YES	thyroid	<u>NO</u> YES	weight loss	<u>NO</u> YES	liver	<u>NO</u> YES
lung infections	<u>NO</u> YES	skin problems	<u>NO</u> YES	ulcers	<u>NO</u> YES	depression	<u>NO</u> YES
						headaches	<u>NO</u> YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? NO YES
11. Have you ever had a blood clot in your lungs, legs or anywhere? NO YES
- *12. Have you ever smoked cigarettes or used smokeless tobacco? NO YES
If yes, are you an: Ex-smoker? Smoking now? Do you smoke (less) (more) than a pack a day?
How much smokeless tobacco do you use a day? _____
- *13. How often do you drink beer, wine, wine coolers, or liquor?
Never Rarely 1-2 times a week 3-4 times a week 5 or more times a week
If you drink beer, wine, wine coolers, or liquor, do you have:
(less) (more) than 5 drinks a day?

- *14. Have you ever used marijuana, cocaine, crack or other drugs? NO YES
- *15. Have you ever used I.V. drugs? NO YES
16. Have you ever had a blood transfusion? NO YES
17. Do you have any tattoos? NO YES
18. Have you ever been treated for a venereal disease? NO YES
19. Have you had more than one sex partner in the past 5 years? NO YES
20. Have you ever had sex with a member of your own sex? NO YES
21. Have you had or been around anyone with hepatitis? NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? _____ Date of your last period? _____
How often do you have your periods? _____ Are they regular? _____
How many days do they last? _____
Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge
- B. Do you have any problems with your breasts (lumps, discharge, or other)? NO YES
Do you check them regularly? YES NO
- *C. How many times have you ever been pregnant? _____ How many children are living? _____
Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? NO YES
Were any of your children premature? NO YES
How old were you when your first child was born? _____
- D. Have you ever used: (circle NO/YES) birth control pills? NO YES; foam? NO YES; condoms? NO YES; IUD? NO YES;
diaphragm? NO YES
- E. Did you have problems with any of these methods? NO YES
- F. Have you ever had an abnormal PAP smear? NO YES