Patient's Name: _____ DOB: _____ Date: _____

Language: _____
☐ **NO Translator needed/Refused**
☐ **Yes, need Translator:**
☐ **Translator Services used** ☐**Refused translator services**
☐ **Certified translator** _____
☐ **Other:**

Allergies & Reaction: _____

Initial Health Appointment (IHA)/ Periodic Health Evaluation:

First 120 days (4 months) of Enrollment and Annually

Please answer the following questions:

Tobacco, Alcohol, & Drug Misuse Screening (TAPS1):

☐ ***I DECLINE TO ANSWER***

In the PAST 12 MONTHS:

1. How often have you used any tobacco products (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?
   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ Never
   - If you smoke tobacco, how long and how much?
     - Years: _____ Months: _____
     - # cigarettes per day: _____

   Former Smoker: Quit Date: _____
2. **Men**: How often have you had 5 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.
   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ Never
3. **Women**: How often have you had 4 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.
   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ Never
4. How often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?
   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ Never
5. How often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you? *Prescription medications that may be used this way include Opiate pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD (for example, Adderall or Ritalin)*
   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ Never

Clinic Use Only:
Risk:
☐ No/Low ☐ High
☐ TAPS 2 Assessment completed

Interventions:
☐ Alcohol or Drug use Counseling
☐ Drug/Detox Tx Rehab
☐ Tobacco Cessation Counseling
☐ Prescription Nicotine Replacement Options
☐ Abdominal Aneurysm Screening (Ultrasonography)
☐ Lung Cancer Screening (Low-Dose CT)
☐ Other:
_____
_____
_____
_____
_____
_____

Depression Screening (PHQ2):

☐ ***I DECLINE TO ANSWER***

Over the last 2 weeks, how often have you been bothered by any of the following problems? *Please circle one response for each question.*	**Not at all**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
1. Little interest of pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
Total Score: *With PHQ-2 score of 3 or more, further evaluate with PHQ-9*				

Clinic Use Only:
Risk: ☐ No/Low ☐ High:
☐ PHQ9score: _____
Interventions:
☐ Education/Counseling
☐ Medication
☐ Refer to Resources
☐ Mental Health Referral

Intimate Partner Violence (HARK):

☐ ***I DECLINE TO ANSWER***

Within the last year, have you been...		
1. Humiliated or emotionally abused in other ways by your partner or your ex-partner?	No	**Yes**
2. Afraid of your partner or ex-partner?	No	**Yes**
3. Raped or forced to have any kind of sexual activity by your partner or ex-partner?	No	**Yes**
4. Kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?	No	**Yes**

Clinic Use Only:
Risk: ☐ No/Low ☐ High
Interventions:
☐ Refer to Resources
☐ Safety Plan
☐ Other: _____

Patient's Name: _____ DOB: _____ Date: _____

HIV/STI Screening:

☐ ***I DECLINE TO ANSWER***

1. ***Are you sexually Active?***	No	**Yes**
2. Have you ever been forced or pressured to have sex?	No	**Yes**
3. ***In the past year,*** have you or your partner(s) had sex without using birth control or condoms?	No	**Yes**
4. ***In the past year,*** have you or your partner(s) had sex with other people?	No	**Yes**
5. Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	**Yes**
6. Would you be interested in testing for HIV/STI?	No	**Yes**

Clinic Use Only:
Risk: ☐ No/Low ☐ High
Interventions:
☐ Safe Sex Practices Counseling (Condoms, Contraception, STIs)
☐ HIV/STI Testing
☐ Other _____

Hepatitis B & C Screening

☐ ***I DECLINE TO ANSWER***

If yes to the following, test for Hepatitis B and C			**Notes**
Have you ever injected drugs not prescribed by a doctor (Person Who Injects Drugs – PWID/intravenous drug use - IDU)?	☐ **Yes**	☐ **No**	
Are you HIV positive? *(Note: annual Hep C testing recommended if HIV+)*	☐ **Yes**	☐ **No**	
Are you a man who have sexual encounters with other men?	☐ **Yes**	☐ **No**	
Have you stayed in jail or prison? *(i.e., Have you ever been incarcerated?)*	☐ **Yes**	☐ **No**	
Have you had hepatitis, liver disease, or elevated liver enzymes (ALT/AST)?	☐ **Yes**	☐ **No**	
Have you ever had sex for money, drugs, or other things you needed?	☐ **Yes**	☐ **No**	
Were you born to a mother infected with Hep B or C? *(Test for whichever is indicated: B or C or both)*	☐ **Yes**	☐ **No**	
If yes to any of the following, test for Hepatitis B only			**Notes**
Country of birth: ☐ **US** ☐ **Other (**If not US, write-in name of country): _____			
Have you ever had sex with and/or living with someone who has Hep B?	☐ **Yes**	☐ **No**	
Have you ever had sex with someone who has sex for money, etc.?	☐ **Yes**	☐ **No**	
Have you had a medical condition requiring immunosuppressive therapy?	☐ **Yes**	☐ **No**	
If yes to any of the following, test for Hepatitis C only			**Notes**
If you are 18 years and older, have you ever been tested for hepatitis C? (test once in lifetime)	☐ **Yes**	☐ **No**	
Have you had a transfusion of blood or organ transplant before July 1992?	☐ **Yes**	☐ **No**	
Have you had clotting factor concentrates produced before 1987?	☐ **Yes**	☐ **No**	
Have you ever had or are you currently having dialysis?	☐ **Yes**	☐ **No**	
Have you ever gotten a tattoo or piercing outside of a licensed parlor?	☐ **Yes**	☐ **No**	
Have you ever snorted, inhaled, and/or injected drugs?	☐ **Yes**	☐ **No**	
Have you ever had sex with someone who has Hepatitis C?	☐ **Yes**	☐ **No**	

Have you ever had Hepatitis B Vaccine? Series? (check all that apply) ☐ Dose 1 ☐ Dose 2 ☐ Dose 3 ☐ Yes ☐ No

☐ I want to be tested for Hepatitis B and/or C

☐ I do **not** want to be tested for Hepatitis B and/or C

Clinic Use Only:
Risk: ☐ No/Low ☐ High
Interventions:
☐ Hepatitis B & C panel
☐ If unimmunized, counseling done
☐ Vaccination
☐ Other: _____

Patient's Name: _____ DOB: _____ Date: _____

Vitals: Temp_____ BP_____ Height _____Weight _____ BMI _____ Measured by _____

Clinic Use Only	***Counseling and Discussion***		
Advance Directive	☐ ***Yes, AHCD on file***	☐ ***No AHCD on file, info given/discussed***	☐ ***Decline***
Nutrition, Diet, Exercise	☐ Healthy Food Choices include whole grains, iron-rich foods, limiting fatty, sugary, processed, & salty foods. ☐ Weight Control and Physical Activity/Exercise		
Safety	☐ Reducing Risky Behaviors (Motor Vehicle Safety, use seat belt, or safety helmet, etc.)		
Dental Health	☐ Routine Dental Care ☐ Referral to Dentist		
Mental Health	☐ Reviewed/Discussed ☐ Referral to Mental Health (Emotional) Support ☐ Other:		
Vision	☐ Reviewed/Discussed ☐ Referral to Optometrist/Ophthalmologist ☐ Other:		
Functional Limitation	☐ Unremarkable ☐ Seeing ☐ Hearing ☐ Mobility ☐ Communication ☐ Cognition ☐ Self-care ☐ Other:		
Social Determinants of Health (SDOH)	☐ WNL-Stable, relationship with social/emotional support ☐ Changes since last visit (move, job, death) ☐ Problems with housing, food, employment, finances, managing medications, transportation, health behaviors, safety, household supplies, ☐ Stressors (mental illness, alcohol/drugs, violence/abuse, family/social support)		
Immunization ☐ Orders: _____ _____ _____ ☐ Decline: _____ _____ _____	☐ Influenza (annually): ☐ Td/Tdap (every 10 years): ☐ Pneumococcal: ☐ Zoster (starting at age 50): ☐ Varicella: ☐ MMR: ☐ COVID-19:		

Review of Systems:	**WNL**	**Comments and/or Abnormal findings**
☐ ***HEENT***	☐	
☐ ***Mouth/Teeth***	☐	
☐ ***Chest/Breast***	☐	
☐ ***Heart***	☐	
☐ ***Lungs***	☐	
☐ ***GI/Abd***	☐	
☐ ***GU***	☐	
☐ ***Extremities***	☐	
☐ ***Back***	☐	
☐ ***Skin***	☐	
☐ ***Neurologic***	☐	

Physical Exam:	**WNL**	**Comments and/or Abnormal findings**
☐ ***HEENT***	☐	
☐ ***Mouth/Teeth***	☐	
☐ ***Chest/Breast***	☐	
☐ ***Heart***	☐	
☐ ***Lungs***	☐	
☐ ***GI/Abd***	☐	
☐ ***GU***	☐	
☐ ***Extremities***	☐	
☐ ***Back***	☐	
☐ ***Skin***	☐	
☐ ***Neurologic***	☐	

Patient's Name: _____ DOB: _____ Date: _____

Screenings:	
Colorectal Cancer Screening	☐ Last Colonoscopy date: _____ ☐ Last FOBT: _____ ☐ Last Cologuard: _____ ☐ Colorectal screening ordered: _____ ☐ Other: _____ ☐ Refused
Diabetic Screening	☐ Lab ordered ☐ Comprehensive Diabetic Care: ☐ Retinal exam ☐ Foot exam ☐ Podiatry referral ☐ Nephrology referral ☐ Counseling ☐ Other: ☐ Refused
Dyslipidemia Screening	☐ *Lipids ordered* ☐ Counseling ☐ Refused
Skin Cancer Counseling	☐ Reviewed/Discussed/Counseled on skin cancer prevention ☐ Referral to Dermatologist ☐ Other:
Tuberculosis Screening: *Latent Tuberculosis Infection Screening*	☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month • Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe • If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list). • Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥2 years old ☐ **Immunosuppression,** current or planned • HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication ☐ **Close contact** to someone with infectious TB disease at any time ☐ **NONE; no Tb risk or testing indicated at this time** ☐ **Tb risk:** _____

Male Specific:		
☐ Abdominal Aneurysm Screening *(65–75-year-old who have ever smoked 100+ cigarettes)* - Ultrasonography	☐ Prostate Cancer Screening done	

Female Specific:		
☐ Breast Cancer Screening done ○ Last Mammogram: ○ Mammogram ordered: _____	☐ Osteoporosis screening done ○ Last Dexa: _____ ○ Dexa ordered: _____	☐ Cervical Cancer Screening done ○ Last PAP: _____ ○ PAP ordered: _____

☐ For Women of Reproductive Ages: Prescribe 0.4 – 0.8 mg of daily folic acid, in addition counsel to consume food with folate from a varied diet, to help prevent neural tube defects.

Next appointment/Follow Up/RTC:

☐ **1 year** ☐ **PRN** ☐ **Other:** _____ years _____ months _____weeks _____days

☐ **PATIENT DECLINED IHA/PERIODIC HEALTH EVALUATION**

PROVIDER SIGNATURE:	**DATE:**