

HIV MEDICAL ASSESSMENT AND EXAMINATION FORM

Date: _____ Reason of visit: Follow up Walk in/Triage Other:

Temp: _____ P: _____ R: _____ B/P _____ Wt _____ lbs (↑↓ _____ since last visit) Allergies: _____

E.R./ Hospital since last clinic visit? No Yes → Date: _____ Facility _____
Reason _____ Staff Initials _____

Identify current medications below:

<input type="checkbox"/> ATRIPLA	<input type="checkbox"/> EMTRIVA	<input type="checkbox"/> TRUVADA	<input type="checkbox"/> INTELENCE	<input type="checkbox"/> APTIVUS	<input type="checkbox"/> LEXIVA	<input type="checkbox"/> VIRACEPT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ABACAVIR	<input type="checkbox"/> EPIVIR	<input type="checkbox"/> VIDEX EC	<input type="checkbox"/> RESCRIPTOR	<input type="checkbox"/> CRIVIVAN	<input type="checkbox"/> NORVIR	<input type="checkbox"/> FUZEON	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> RETROVIR	<input type="checkbox"/> EPZICOM	<input type="checkbox"/> VIREAD	<input type="checkbox"/> SUSTIVA	<input type="checkbox"/> INVIRASE	<input type="checkbox"/> PREZISTA	<input type="checkbox"/> SELZENTRY	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> COMBIVIR	<input type="checkbox"/> TRIZIVIR	<input type="checkbox"/> ZERIT	<input type="checkbox"/> VIRAMUNE	<input type="checkbox"/> KALETRA	<input type="checkbox"/> REYATAZ	<input type="checkbox"/> ISENTRESS	<input type="checkbox"/>	<input type="checkbox"/>

Adherence Reported by Client: Not on ARV's Missed _____ doses last month _____ % Adherence

Review of Systems (✓ if asked and Negative. Circle if Abnormal and Describe Below)

- | | | |
|--|--|--|
| <input type="checkbox"/> Pain
1 2 3 4 5 6 7 8 9 10
Location: _____ | <input type="checkbox"/> Cough/Phlegm
<input type="checkbox"/> Dyspnea/Wheezing
<input type="checkbox"/> Odyno/Dysphagia
<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Diarrhea/Constipation
<input type="checkbox"/> Genital/rectal symptoms
<input type="checkbox"/> Numb/Weakness
<input type="checkbox"/> Skin rash/Lesion | Female: LMP: _____
<input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> N/A |
| <input type="checkbox"/> Anorexia | | |
| <input type="checkbox"/> Fatigue | | |
| <input type="checkbox"/> Fever | | |
| <input type="checkbox"/> Night sweats | | |
| <input type="checkbox"/> Headache | | |
| <input type="checkbox"/> Visual Complaint | | |
| <input type="checkbox"/> ENT/Thrush | | |

Physical Exam	Mark if examined and Normal	Abnormal/Notable Findings (Write the corresponding number of the abnormal exam and explain in this section)
1) General	<input type="checkbox"/> Alert and oriented <input type="checkbox"/> Well nourished/developed	
2) HEENT	<input type="checkbox"/> PERRLA, EOM <input type="checkbox"/> Anicteric sclera <input type="checkbox"/> No oral lesions <input type="checkbox"/> Ear canal/TM <input type="checkbox"/> Nose <input type="checkbox"/> Dental	
3) Lungs/Resp	<input type="checkbox"/> Clear to auscultation	
4) Heart	<input type="checkbox"/> RRR, no murmur, S3, /4 <input type="checkbox"/> No edema <input type="checkbox"/> Periph. Pulse 2+	
5) Abdomen	<input type="checkbox"/> Soft/depressible <input type="checkbox"/> Bowel sounds present <input type="checkbox"/> Nontender <input type="checkbox"/> No organomegaly	
6) Skin	<input type="checkbox"/> No rash <input type="checkbox"/> No lesions <input type="checkbox"/> No nail changes	
7) Lymphs	<input type="checkbox"/> No adenopathy <input type="checkbox"/> cervical <input type="checkbox"/> axillary <input type="checkbox"/> inguinal	
8) Ano-genital	<input type="checkbox"/> No anal/genital lesions/mass/discharge <input type="checkbox"/> Hemocult + -	
9) Neuro/psych	<input type="checkbox"/> No motor/sensory deficits <input type="checkbox"/> Cranial nerves intact	

Other: _____

Date _____	(Label Here)
_____ Sign/Title	Last Name: _____ First Name: _____
	I.D. # _____ DOB: _____

Lab:

CD4 absolute count _____ CD4 % _____ (Date: ___/___/___) Viral Load _____ (Date: ___/___/___)

Comments on other Lab Findings, Date if different from above.

Transmission & Re-infection Prevention

Safe sex discussed: Yes No
Sexual history: # of partners since last visit: _____
Condom use discussed Yes No Condoms Given
Contraception discussed Yes No N/A
Method: _____
Injection Drug Use Yes No
Other Street Drugs Yes No
Drugs: _____

Health Maintenance

1. Importance of 100% Adherence Yes No N/A
2. ETOH Yes No _____/day
3. Smoker Yes No _____ packs/day
Smoking cessation Yes No
4. Advised of Potential Drug Interactions Yes No N/A
5. Nutritional Status _____
6. Exercise/Activity _____
7. Other _____

Assessment: HIV+ (non-AIDS) asymptomatic (V08) AIDS (042)

Plan: No ARV's indicated Continue current regimen Change as follows:

Vaccines: **Review Florida Shots → Record Included. Up-to-date Needs:

PPD: Up-to-Date Needs PPD Previous positive

Client referred to: Dentist Nutritionist Colonoscopy Imaging:

Other:

FOLLOW-UP CLINIC APPT: In _____ wks In _____ months Other:

Annual PE next Clinic visit PAP test next Clinic visit Other:

Labs: Today () _____ weeks

- () CBC
- () CD4
- () HIV-VL Quant
- () CMP Profile
- () BMP
- () Fasting Lipid Profile
- () HIV Genotype
- () HIV Virtual Genotype
- () HIV Phenotype
- () Trofile

- () Liver function test (LFT)
- () HBsAb Quant
- () HBV VL Quant
- () HCV VL Quant
- () HCV Genotype
- () RPR FTA ABS
- () Hemoglobin A1C
- () PSA
- () TSH
- () Testosterone Free (Total)
- () HLA-B*5701

- () Sputum C+S
- () Sputum AFB X 3
- () Blood C+S AFB
- () U/A () Urine C/S
- () Spot urine micro – albumin / creatinine
- () U/A Aptima for GC/CT
- () _____
- () _____
- () _____
- () _____

Date _____ Time _____

(Label here)

Last Name: _____ First Name: _____

ID# _____ DOB: _____

**Instructions for HIV Medical Assessment and Examination Form
DH Form 2137, December 2008**

Purpose: This form provides a record of the follow-up office visit(s) of the Adolescent or Adult HIV infected patient presenting to our county health departments. Use the Adult & Adolescent Health History Form DH 3113 and the Adult & Adolescent Physical Examination Form DH 3137 for the Initial Visit by the client.

Date: Enter the date of the patients visit for the evaluation

Reason for Visit: Place a check mark appropriately identifying the occurrence for the visit.

Temp: Enter the patient's temperature in Fahrenheit.

P (Pulse): Enter pulse rate for one minute.

R (Respiration): Enter respiration rate for one minute.

B/P (blood pressure): enter blood pressure with systolic measure/diastolic measure.

Wt (Weight): enter weight measured in pounds.

(↑ ↓ _____ **since last visit**): circle the up or down arrow appropriate for this weight and enter in the blank the number of pounds the weight has increased or decreased since the last visit.

Allergies: Enter names of the medication(s) to which the patient is allergic. If medications are consistently by clinic standard listed on the medication record, you may enter no Δ where the delta symbol abbreviates the word 'change' or you may enter 'see Medication Profile Form.' Update the Medication Profile Form DH 3116 with current allergies as well – this provides one standard location for allergies within the medical record.

E.R./Hospital since last clinic visit? Check yes or no.

Date: Enter the date of the ER or Hospital visit since the last visit if answered yes.

Facility: Enter the name of the ER or Hospital Facility.

Reason: Enter the reason for the ER or Hospital Facility visit.

Staff initials: Initial and title of the person obtaining the above information.

Identify current medications below: Using a check mark, note the current ARV (anti-retroviral) medications the patient is taking.

Adherence Reported by Client: Check appropriate box: Not on ARVs. Check appropriate box if patient missed any ARV dose since the last visit. In the blank, enter the number of doses estimated by the patient missed since the last visit. A **DOSE** is defined as one time period in which the patient should have taken ARV medication(s). For example if the patient takes two separate **ARV** medications in the morning and one **ARV** medication in the evening, he/she has two **DOSES** per day. If this patient reports missing two doses in the last month, you calculate the **% Adherence** as follows: 2 doses of ARV medication/day X 30 days = 60 doses. There were 58 doses taken as there were

2 missed doses. Thus the % adherence is calculated by dividing 58 by 60 and multiplying the result by 100. $58/60 = .96 \times 100 = 96\%$ accuracy.

Review of Systems (✓ if asked and Negative. Circle if Abnormal and Describe Below): it is expected that the patient will be asked their PAIN on a scale. A check mark without a circle of the numbers 1 through 10 indicates the patient does not have pain. If pain is present ask the patient to rate the pain on a scale of 1-10 where 1 is mild pain and 10 is the worst pain they have ever had in their life. Circle what the patient reports as their level of pain and enter the **Location** of the pain in the space provided. The reviews of systems items are those that are commonly positive of an HIV patient. Routinely asking several of these randomly at each clinic visit is recommended. Significant history obtained from the patient in answer of these questions should be described in the blank space provided in this section. All female patients every visit should have the menstrual information completed. **This blank space can as well be used by clinical staff to document subjective complaints of the patient on their visit.** Staff should review the plan from the prior office visit and address whether or not it was completed and notate any positive or negative findings in this area.

Physical Exam Section: A check mark signifies the appropriate examination was performed and the finding was within normal limits. Abnormalities are to be described in the blank space provided. Use the number of the appropriate system and define the abnormality.

Other: This area is open to additional provider comments not addressed above.

Date/Sign/Title: This is the date of the patient visit along with signature and title of the examining clinician.

(Label Here): Chart label may be appended here and if unavailable, hand write the last name and first name of the patient, as well as chart identification number/letters and patients date of birth (DOB).

Lab: Since the last visit for review of CD4 and Viral Load, enter most recent CD4 absolute count, CD4 % and Viral load including appropriate dates of lab.

Comments on other Lab Findings, Date if different from above. This section is for the clinician to enter pertinent positives or negative lab results reviewed with the patient on this visit. These labs only need to be dated if the date is different from the above CD4 and Viral load data entered.

Transmission and Re-infection Prevention and Health Maintenance Section: It is expected the issues of sex/condom use/drug use will be discussed at each patient visit. One or more pertinent patient health maintenance issues should be addressed at each visit. Note as well this section can be done by any member of the health care team.

Assessment: Check appropriate box for HIV status, and on the following lines, list diagnosis pertinent for this visit date. It is expected the diagnosis, if a chronic condition(s), will also be placed on the patients problem list.

Plan: Check appropriate box for ARV status, and on following line, define the plan of care related to the assessments for this visit.

Vaccines: Review the Florida Shots record. Check if up to date or enter the needed service(s).

PPD: Check mark if current, PPD needed or if previously positive. The blank space can be used to track the date due or add comments.

Client referred to: Check mark if referred to Dentist/Nutritionist/Colonoscopy or Imaging(X-ray). Space provided to write in specifics for Imaging. Define other type referral in the blank space provided.

Follow-up Clinic Appt: Check the correct interval for the next clinic visit date. Note by check mark as well if Annual PE/Pap test or other significant exam is needed at next clinic visit.

Labs: Most common routine labs are listed for check mark ordering as well as blank spaces for write-ins. The if checked means the lab is ordered to be drawn this visit date. The () space if checked connotes the lab is to be done at a future date. Fill in the blank at the top of this section to note the interval in weeks at which time the future lab is to be done. Additional lines are available to write in labs not listed.

Date/Time/Sign/Title: At the end of this patient clinician visit, enter the date/time as well as signature and title. (MD, ARNP, PA, other)

(Label Here): Chart label may be appended here and if unavailable, hand write the last name and first name of the patient, as well as chart identification number/letters and patients date of birth (DOB).