

# Encounter Form

PCP:

Name:

ID #:

Age:

Gen.:

Site:

Provider:

Date:

Time:

## Patient Needs

Adult Pneumovax for Chronic Illness

Tdap Vaccine

Asthma - Confirm: Care Plan within one year

Advise Tobacco Cessation

## Chronic Problems (write in changes)

Foot Pain : Bilateral

Osteoarthritis

Acquired Pes Planus

Tobacco Abuse

Marijuana Abuse

Asthma (Persistent)

Skin Tag

Morbid Obesity

Complaint of Infertility (Male)

## Recent Acute Problems (write in changes)