

Reason for Visit: <input type="checkbox"/> New <input type="checkbox"/> Sick Call <input type="checkbox"/> Follow-Up <input type="checkbox"/> Walk-In	Vital Signs: Age: _____ years Height: _____ feet _____ inches Temp: _____ ° F Pulse: _____ Resp: _____ BP _____ / _____ (L / R) Weight: _____ lbs (↑ ↓ _____ lbs since last visit) Sex: (Circle) Male Female Transgender Signature/Title _____	Chart # _____
---	--	-------------------------

Allergies:

Any visit to E.R. since last clinic visit? No Yes → Date: _____ Facility _____ Reason _____
 Any hospitalization since last clinic visit? No Yes → Date: _____ Facility _____ Reason _____

Tobacco No Yes Amt _____ **ETOH** No Yes Amt _____ **Street Drugs** No Yes Type/Amt _____

Domestic Violence Do you feel you are being physically or emotionally abused or neglected? (circle) Yes No

Current ART Regimen ART Naïve Not Currently Indicated Client Stopped Not Interested Temporary Hold

<input type="checkbox"/> AZT / Retrovir	<input type="checkbox"/> CBV / Combivir	<input type="checkbox"/> f-APV / Lexiva	<input type="checkbox"/> RTV / Norvir	<input type="checkbox"/> EFV / Sustiva
<input type="checkbox"/> D4T / Zerit	<input type="checkbox"/> TZV / Trizivir	<input type="checkbox"/> TPV / Aptivus	<input type="checkbox"/> NFV / Viracept	<input type="checkbox"/> NVP / Viramune
<input type="checkbox"/> DDI / Videx / EC	<input type="checkbox"/> 3TC-ABC / Epzicom	<input type="checkbox"/> DRV / Prezista	<input type="checkbox"/> APV / Agenerase	<input type="checkbox"/> ETR / Intelence
<input type="checkbox"/> 3TC / Efavirenz	<input type="checkbox"/> TDF-FTC / Truvada	<input type="checkbox"/> IDV / Crixivan		<input type="checkbox"/> DLV / Rescriptor
<input type="checkbox"/> ABC / Ziagen		<input type="checkbox"/> ATV / Reyataz	<input type="checkbox"/> RAL / Isentress	
<input type="checkbox"/> TDF / Viread	<input type="checkbox"/> ATR / Atripla (Truvada & Sustiva)	<input type="checkbox"/> SQV / Invirase	<input type="checkbox"/> MVC / Selzentry	<input type="checkbox"/> Research Study Drugs
<input type="checkbox"/> FTC / Emtriva		<input type="checkbox"/> LPV/r / Kaletra	<input type="checkbox"/> T20 / Fuzeon	

PCP Prophylaxis: No clinical indication Not taking TMP-SMX Dapsone Atovaquone Pentamidine

MAC Prophylaxis: No clinical indication Not taking Azithromycin Clarithromycin Rifabutin

Chief Complaint / Review of Systems (circle) Initial evaluation reviewed Re-admission notes reviewed

Fatigue	No	Yes	Fever	No	Yes
Nausea	No	Yes	Night Sweats	No	Yes
Vomiting	No	Yes	Neuropathy	No	Yes
Diarrhea	No	Yes	Dysphagia	No	Yes
Anorexia	No	Yes	Otalgia	No	Yes
Dyspnea	No	Yes	Lymphadenopathy	No	Yes
Cough	No	Yes	Visual Complaints	No	Yes
Thrush	No	Yes	Headache	No	Yes

Physical Exam	Mark Normal Findings	Abnormal/Notable Findings
General <input type="checkbox"/> Examined <input type="checkbox"/> Not Examined	<input type="checkbox"/> Well developed <input type="checkbox"/> Well nourished <input type="checkbox"/> Alert and oriented X 3	_____
HEENT <input type="checkbox"/> Examined <input type="checkbox"/> Not Examined	<input type="checkbox"/> PERRL <input type="checkbox"/> Normal conjunctivae/lids <input type="checkbox"/> EOMI <input type="checkbox"/> Oral cavity moist / w/o lesions <input type="checkbox"/> No thyromegally /nodules <input type="checkbox"/> Ears CCL	_____
Lungs <input type="checkbox"/> Examined <input type="checkbox"/> Not Examined	<input type="checkbox"/> Normal respiratory effort <input type="checkbox"/> Clear to auscultation	_____
Cardiovascular <input type="checkbox"/> Examined <input type="checkbox"/> Not Examined	<input type="checkbox"/> Regular rate & rhythm <input type="checkbox"/> Peripheral pulses 2+ <input type="checkbox"/> No murmur, gallop or rub <input type="checkbox"/> No pedal edema, clubbing or cyanosis	_____
Abdomen <input type="checkbox"/> Examined <input type="checkbox"/> Not Examined	<input type="checkbox"/> Bowel sounds active and normal <input type="checkbox"/> Soft, non-tender <input type="checkbox"/> No distention <input type="checkbox"/> No organomegally <input type="checkbox"/> No palpable masses	_____
Skin <input type="checkbox"/> Examined <input type="checkbox"/> Not Examined	<input type="checkbox"/> No rashes or lesions <input type="checkbox"/> No petechiae, purpura or unusual nevi	_____
Lymph <input type="checkbox"/> Examined <input type="checkbox"/> Not Examined	<input type="checkbox"/> No neck lymphadenopathy <input type="checkbox"/> No axillae lymphadenopathy	_____
Genitourinary <input type="checkbox"/> Examined <input type="checkbox"/> Not Examined	<input type="checkbox"/> Normal genitalia <input type="checkbox"/> No masses or lesions	_____
Neurological <input type="checkbox"/> Examined <input type="checkbox"/> Not Examined	<input type="checkbox"/> No gross deficits <input type="checkbox"/> Normal reflexes <input type="checkbox"/> Motor/sensory/cerebellar, cranial nerves intact	_____
Musculo-skeletal <input type="checkbox"/> Examined <input type="checkbox"/> Not Examined	<input type="checkbox"/> Full range of motion <input type="checkbox"/> No joint tenderness or swelling	_____

TAMPA Care Clinic Progress Record Page 1 of 2	Patient Name _____ Signature: _____ Date: _____
--	---

Assessment:

CD4 abs _____ (Date: / /)
CD4 % _____ (Date: / /)
Viral Load _____ (Date: / /)

Other Lab findings:

ARV Adherence Reported by Client: N/A Not assessed Missed _____ doses last month out of expected _____ doses

Education/ Counseling Provided	Importance of 100% Adherence <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Health Maintenance discussed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	Drug Resistance <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
	Potential Drug Interactions <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
	Other Aspects of Drug Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Regarding	Contraception discussed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	HIV Prevention discussed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	Contraception discussed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
	Contraception discussed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

Pain: (circle) Yes No Onset: _____ Location: _____
Type (circle): Dull Sharp Crushing
Acute Intermittent Constant
Pain Score: _____ Pain Goal: _____ Relieved by: _____ Worsened by: _____ Treatment: _____

1 HIV (non-AIDS) AIDS **Classification: (circle)** A1 A2 A3 B1 B2 B3 C1 C2 C3

2	6
3	7
4	8
5	9

Plan: Continue current ARV regimen Continue current prophylaxis for OI's N/A

Client referred to:
 Dietician
 Dentist (contact info given)
 Social Worker
 GYN / OB
 Eye (ophtho/opto)
 Other: _____
 Other: _____

Vaccines up to date
 Pneumovax Influenza PPD Hepatitis B #1 / #2 / #3 Hepatitis A #1 / #2 Twinrix #1 / #2 / #3

Lab: (Circle)
Today CBC CMP BMP LFTs CD4 HIV VL CRP Hep Profile RPR Toxo CMV U/A GC/Chlam Urine CPK
In _____ weeks CBC CMP BMP LFTs CD4 HIV VL CRP Hep Profile RPR Toxo CMV U/A GC/Chlam Urine CPK

Other Labs:
RTC (weeks): (circle) 1 2 3 4 5 6 7 8 10 12 14 16 Other _____
App't with: (circle) ARNP MD

Tampa Care Clinic
Progress Record
Page 2 of 2
Signature: _____
Date: _____
Patient Name _____