

PATIENT ENCOUNTER FORM
University Health Associates
Physician Office Center
Department of Medicine
Infectious Diseases

Date of Diagnosis: ___ / ___ / ___ Year likely infected _____

Risk: IDU MSM Heterosexual Contact Perinatal Trans Hemophilia/Coag Disorder/Transfusion Undetermined

<u>LABS</u>	<u>DATE</u>	<u>RESULT</u>	<u>INVESTIGATION</u>	<u>DATE</u>	<u>RESULT</u>
CD4 count (percentage)			Syphilis/Gc / Chlamydia		
			Toxoplasma IgG		
			Hep B sAg / sAb		
			Hep B Core Ab / IgM		
			Hep C Ab		
NADIR CD4			Hep A Total Ab / IgM		
Viral Load			PPD		
			Pap Smear		
			Eye Exam		
			Dental Exam		
			Lipid Screening		
Resistance Testing			Nutrition Screening		
			Mental Health Screening		
			HIV Education		
			Prevention and Wellness		
			Patient Assessment Form		
			Living Will / MPOA		
Opportunistic Infections/ Neoplasms/ Comorbids			VACCINATIONS	DATE	
1	6		Pneumococcal		
2	7		Influenza		
3	8		Hepatitis A		
4	9		Hepatitis B #1		
5	10		Hepatitis B #2		
Allergies / Adverse Rx to prior ART therapy			Hepatitis B #3		
			Tetanus/Diphtheria		
Medications	Dose/Freq	Start Date	Stop Date	Reason	
Medications for Prophylaxis	Dose/Freq	Start Date	Stop Date	Reason	

Additional Notes: