Name Age DOB Date ☐ EFUP ☐ NEW ☐ CONSULT

# HISTORY - COMPLETED BY PATIENT, STAFF, OR PROVIDER

**1. Reason for your visit today** _____

**2. Please indicate if you are having any <u>current</u> problems or symptoms in any of the following areas:**

☐ General Wellness
☐ Eyes
☐ Skin
☐ Ears, Nose, Throat
☐ Psychiatric
☐ Lungs/Breathing
☐ Heart/Circulation
☐ Neurological
☐ Allergies
☐ Reproductive/Urinary
☐ Thyroid/Diabetes
☐ Blood/Lymph
☐ Muscles/Joints/Bones

☐ **Nausea/Vomiting** ☐ **Heartburn** ☐ **Swallowing problems**
☐ **Bowel Changes** ☐ **Blood in stool** ☐ **Black stool**
☐ **Abdominal pain** ☐ **Chest Pain** ☐ **Weight loss**
☐ **Transfusion** ☐ **Other**_____

**Physician Comments - Review of Systems**

☐ All other systems negative

ROS: 1 prob. pertinent, 2-9 extended, 10+complete

**3. Medication (name and dosage of each)**

**4. Previous Surgeries/Dates including COLONOSCOPY, GASTROSCOPY, ERCP:**

**5. Allergies to drugs and type of reaction:**

**Reactions to anesthesia:**

**6. What is your Social History?**

Marital Status: Single ☐, Divorced ☐, Married ☐, Widow/Widower ☐, Who lives with you? _____

Current Occupation/Employer _____What kind of work? _____

Do you smoke? _____How many packs a day?_____For how many years? _____

Do you drink alcohol? _____How many drinks per day?_____ per week?_____per month? _____

Are you sexually active? _____Do you use illicit drugs?_____ If yes, what kind? _____

**7. What is the Health Status of Your Family?**

Mother:_____

Father: _____

Brothers/Sisters:_____

**Family Illnesses:**

Colon polyps/cancer ☐ Crohn's/Ulcerative Colitis ☐ Liver disease ☐
Stomach/pancreas/esophagus cancer ☐ Breast/uterus/ovary cancer ☐

## HISTORY - COMPLETED BY PROVIDER

**Patient evaluated at the request of:** _____

**Chief Complaint:** _____

**History of Present Illness:** *(Location, Quality, Timing, Severity, Duration, Context, Modifying Factors, Assoc. signs/symptoms) (1.3 brief, 4+ extended)*

Location

Quality

Severity

Duration

Context

Provocative/Palliative Factors

Associated signs and symptoms

Timing

**Prior Evaluation**

**Prior Therapy**

**OR Status of Chronic or Inactive Conditions** (3 *or more = extended w/o HPI)*

***I have reviewed the History as documented above and personally noted the Chief Complaint and HPL***

_____ _____

***signature of provider (attending)*** ***date***

**Name:** **Date:**

## EXAM

**1. Constitution** •BP_____ • P_____ • R_____ • T_____ • Height_____ • Weight_____

• Appearance: ☐ Well Developed ☐ Ill-Appearing ☐ Cachectic

| | | **Abnormal or Positive Findings** |
|---|---|---|
| **2. Eyes** | | |
| • Conjunctivae and lid | ☐ Normal | _____ |
| • Pupils and irises | ☐ Normal | _____ |
| **3. Ears/Nose/Mouth/Throat:** | | |
| • Teeth, gums, lips | ☐ Normal | _____ |
| • External inspection of ears and nose | ☐ Normal | _____ |
| **4. Neck** | | |
| • Neck | ☐ Normal | _____ |
| • Thyroid | ☐ Normal | _____ |
| **5. Respiratory** | | |
| • Percussion | ☐ Normal | _____ |
| • Auscultation/breath sounds | ☐ Clear | _____ |
| **6. Cardiovascular** | | |
| • Heart sounds, murmurs | ☐ Normal | _____ |
| • Pedal pulses | ☐ Normal | _____ |
| • Extremity edema/varicosities | ☐ Absent | _____ |
| **7. Lymph nodes** | | |
| • Axillary | ☐ Normal | _____ |
| • Inguinal | ☐ Normal | _____ |
| **8. Gastrointestinal** | | |
| • Bowel Sounds | ☐ Normal | _____ |
| • Tenderness/Masses | ☐ No | _____ |
| • Hepatosplenomegaly | ☐ No | _____ |
| • Hernia | ☐ No | _____ |
| • Anus, perineum, and rectum | ☐ Normal | _____ |
| Other_____ | ☐ Normal | _____ |
| • Obtain stool sample (if indicated) | ☐ Normal | _____ ☐ Pt. Refused ☐ Deferred |
| **9. Musculoskeletal** | | |
| • Gait w/notation of ability | ☐ Normal | _____ |
| Exercise program | ☐ | _____ |
| • Assessment of muscle strength & tone | ☐ Normal | _____ |
| **10. Skin** | | |
| • Inspect skin & SC tissue | ☐ Normal | _____ |
| • Palpation | ☐ Normal | _____ |

**11. Psychiatric**

- Oriented: Person, Place, Time ☐ Yes _____
- Mood & affect (depressed, anxious) ☐ No _____

*(99201 = 1-5 bullets, 99202 = 6 bullets, 99203 = 2 bullets in 6 areas/systems, 99204/99205 = 2 bullets in 9 areas/systems)*

***[For services involving residents/fellows:***
***I personally examined the area(s) above identified with my initials and reviewed the remaining exam performed by***

***Dr._____.]***

_____ _____

***signature of provider (attending)*** ***date***

## IMPRESSION

## PLAN

(When more than 50% of physician face-to-face time with patient involved counseling and/or coordination of care)

**Face-to-face time with patient _____**

**Time spent in counseling and/or coordination of care_____**

**Discussion:**