DOCTOR'S NOTE

CLINICAL DOCUMENTATION TEMPLATE

1 Patient Identification

Name: _____ MRN: _____

DOB / Age: _____ Date of Service: _____

Sex: _____ Location of Service: _____

Provider Name & Credentials: _____

2 Visit Type

Visit type: _____

3 Reason for Visit

Presenting concern: _____

4 History of Present Illness

Onset: _____ Severity: _____

Duration: _____ Timing: _____

Course: _____ Context: _____

Location: _____ Modifying factors: _____

Quality: _____ Associated symptoms: _____

PERTINENT POSITIVES / NEGATIVES

Pertinent positives and negatives relevant to the presenting complaint...

5 Past Medical History

CHRONIC CONDITIONS

Chronic conditions and relevant prior diagnoses...

6 Past Surgical History

Surgeries and approximate dates...

7 Medications

Name, dose, frequency, and adherence for each medication...

8 Allergies

Drug allergies: _____

Non-drug allergies: _____

Reaction type: _____

9 Family History

Relevant hereditary conditions...

10 Social History

Occupation: _____

Living situation: _____

Tobacco use: _____

Alcohol use: _____

Substance use: _____

11 Review of Systems

Constitutional: _____

Cardiovascular: _____

Gastrointestinal: _____

Musculoskeletal: _____

Psychiatric: _____

Hematologic / Lymphatic: _____

HEENT: _____

Respiratory: _____

Genitourinary: _____

Neurologic: _____

Endocrine: _____

Allergic / Immunologic: _____

12 Vitals

BP: _____ HR: _____ RR: _____

Temperature: _____ O_2 Saturation: _____ BMI: _____

13 Physical Examination

SYSTEM	FINDINGS
General	
HEENT	
Neck	
Cardiovascular	
Respiratory	
Abdomen	

Musculoskeletal	
Neurologic	
Skin	
Psychiatric	

14 Diagnostic Data Reviewed

LABS

Laboratory results reviewed...

IMAGING

Imaging results reviewed...

EXTERNAL RECORDS

External records or prior notes reviewed...

A Assessment

15 PRIMARY DIAGNOSIS

Diagnosis:

Status:

16 DIFFERENTIAL DIAGNOSES

Differential diagnoses with pertinent positives and negatives...

17 PROBLEM LIST

Active problems addressed at this visit...

P Plan

18 MEDICATIONS

New, changed, or discontinued medications...

19 DIAGNOSTICS

Labs, imaging, or other studies ordered...

20 PROCEDURES

Procedures performed or ordered...

21 REFERRALS

Referrals made and reason...

22 COUNSELING

Counseling provided to patient...

23 ACTIVITY RESTRICTIONS

Activity or work restrictions if applicable...

24 FOLLOW-UP

Return in: _____

Instructions: _____

25 Time Documentation

Total time spent: _____ **Counseling / coordination time:** _____

PROVIDER SIGNATURE

Provider name & credentials: _____ **Date / Time:** _____

Signature: _____