MARVIX AI

HISTORY OF PRESENT ILLNESS NOTE

HPI CLINICAL DOCUMENTATION TEMPLATE

Questions? Visit us at www.marvix.ai

1 Patient Information

1 PATIENT DETAILS

Name: _____ Date of Service: _____

DOB / Age: _____ Provider: _____

MRN: _____ Visit type: _____

CC Chief Complaint

2 PRIMARY PRESENTING SYMPTOM

Document the primary presenting symptom in the patient's own words when possible — include duration and setting of onset...

H History of Present Illness

3a ONSET, DURATION & COURSE

Onset / circumstances: _____ Prior episodes: _____

Duration since onset: _____ Timing / pattern: _____

Course (improving/worsening/intermittent): _____ Context (rest/exertion/trauma): _____

3b LOCATION, QUALITY & SEVERITY

Location: _____ Severity (0-10): _____

Radiation or spread: _____ Functional limitation: _____

Character / quality: _____ Quantified impact: _____

3c MODIFYING FACTORS & ASSOCIATED SYMPTOMS

Aggravating factors: _____

Alleviating factors (incl. medications): _____

Associated symptoms supporting or refuting potential diagnoses. Pertinent negatives — explicit denial of key red-flag symptoms relevant to the differential diagnosis...

9 Review of Systems

4 SYSTEM-BASED SYMPTOM REVIEW

Constitutional: _____ Genitourinary: _____

Cardiovascular: _____ Musculoskeletal: _____

Respiratory: _____ Neurological: _____

Gastrointestinal: _____ Psychiatric: _____

Document additional systems as relevant to the presenting complaint — include pertinent positives and pertinent negatives...

V Vital Signs

5 MOST RECENT VITAL SIGNS

Temperature:		Respiratory Rate:	
Blood Pressure:		O2 Saturation:	
Heart Rate:		Height / Weight (if relevant):	

E Physical Examination

6 FOCUSED OR COMPREHENSIVE EXAM FINDINGS

General Appearance:		Abdomen:	
HEENT:		Musculoskeletal:	
Cardiovascular:		Neurological:	
Respiratory:		Skin:	
Psychiatric (if relevant):			

L Lab & Imaging Results

7a LABORATORY STUDIES

Key abnormal values and pertinent normal results — include test name, result, reference range, and date...

7b IMAGING & OTHER DIAGNOSTICS

Findings from X-ray, CT, MRI, ultrasound, ECG, or bedside tests — include date, modality, and interpretation summary...

A Assessment

8 WORKING DIAGNOSIS & CLINICAL IMPRESSION

Working diagnosis or differential diagnoses. Clinical impression based on history, exam, and available data. Severity and acuity. Relevant risk factors or comorbidities influencing clinical judgment...

P Plan

9a DIAGNOSTICS & THERAPEUTICS

Diagnostic evaluation ordered — labs, imaging, further testing. Therapeutic interventions — medications prescribed, procedures, supportive care. Referrals or consultations indicated...

9b PATIENT INSTRUCTIONS & EDUCATION

Instructions given to patient — activity, diet, medication use, warning signs. Education topics covered. Return precautions discussed...

F Follow-Up

10 FOLLOW-UP PLAN

Follow-up in: _____

Earlier if: _____

Reassess: _____

Provider name & credentials: _____ Date / Time: _____

Signature: _____ Facility: _____

NPI: _____ Visit type: _____