MARVIX AI

MEDICAL CHART TEMPLATE

COMPREHENSIVE CLINICAL DOCUMENTATION

Questions? Visit us at www.marvix.ai

1 Patient Information

1 PATIENT DETAILS

Name:		Date of Service:	
DOB:		Provider:	
Age / Sex:		Facility:	
MRN:		Visit type:	

CC Chief Complaint

2 PRIMARY REASON FOR VISIT

Document the primary reason for the visit in the patient's own words when possible — include duration...

H History of Present Illness

3 HPI NARRATIVE

Onset:		Severity (0-10):	
Location:		Timing / pattern:	
Duration:		Aggravating factors:	
Character / quality:		Alleviating factors:	

Associated symptoms. Relevant prior episodes. Pertinent negatives (explicit denial of key red-flag symptoms). Impact on daily functioning...

4 Past Medical History

4a CHRONIC CONDITIONS

List all chronic conditions with approximate year of diagnosis — hypertension, diabetes, cardiac disease, etc...

4b PRIOR HOSPITALIZATIONS & SURGERIES

List hospitalizations with reason and date. List surgeries with procedure and date...

5 Medications

5 CURRENT MEDICATIONS

Name, dose, frequency for all current medications — prescription, OTC, supplements, and vitamins...

6 Allergies

6 KNOWN ALLERGIES & REACTIONS

Drug, food, and environmental allergies — include reaction type and severity for each. Note NKDA if applicable...

7 Family History

7 HEREDITARY & FAMILIAL CONDITIONS

Relevant hereditary or chronic conditions by relation — include age of onset and outcome where known...

8 Social History

8 SOCIAL CONTEXT

Occupation:		**Living situation:**	
Tobacco use:		**Exercise habits:**	
Alcohol use:		**Diet:**	
Substance use:		**Functional baseline:**	

9 Review of Systems

9 SYSTEM-BASED SCREENING

Constitutional:		**Neurological:**	
Cardiovascular:		**Musculoskeletal:**	
Respiratory:		**Psychiatric:**	
Gastrointestinal:		**Genitourinary:**	
HEENT:		**Endocrine:**	
Dermatologic:		**Hematologic / Lymphatic:**	

10 Physical Examination

10a VITAL SIGNS

BP:		**Temperature:**	
HR:		**O2 Saturation:**	
RR:		**BMI:**	

10b EXAMINATION FINDINGS

General appearance: _____ Abdomen: _____

HEENT: _____ Musculoskeletal: _____

Cardiovascular: _____ Neurological: _____

Respiratory: _____ Skin: _____

A Assessment

11a PRIMARY DIAGNOSIS & DIFFERENTIALS

Primary diagnosis and differential diagnoses with ICD-10 codes. Clinical reasoning — explain basis for diagnosis. Severity and stability...

11b RELEVANT RISK FACTORS & COMORBIDITIES

Comorbidities influencing clinical judgment. Risk stratification. Contributing factors to current presentation...

P Plan

12a DIAGNOSTIC TESTS ORDERED

Labs, imaging, or other diagnostics ordered — specify name, indication, and urgency...

12b MEDICATIONS & PROCEDURES

New prescriptions, medication changes, or discontinuations. Procedures performed or planned...

12c PATIENT EDUCATION & REFERRALS

Patient education topics discussed. Referrals placed — specialty and reason. Return precautions reviewed...

D Disposition & Follow-Up

13a DISPOSITION

Disposition (discharge/admit/observation): _____

Condition at time of disposition: _____

13b FOLLOW-UP

Return in: _____

Purpose of follow-up: _____

Earlier if: _____

Provider name & credentials: _____ Date / Time: _____

Signature: _____ Facility: _____

NPI: _____ Visit type: _____