1 Patient Information

1 PATIENT DETAILS

Name:		**Date of Visit:**	
DOB / Age:		**Provider:**	
MRN:		**Specialty / Dept:**	

2 Constitutional

Fever:
Chills:
Weight loss:
Weight gain:
Fatigue:

3 HEENT

Vision changes:
Hearing changes:
Nasal symptoms:
Throat symptoms:

4 Cardiovascular

Chest pain:
Palpitations:
Syncope:
Edema:

5 Respiratory

Shortness of breath:
Cough:
Wheezing:

6 Gastrointestinal

Nausea:
Vomiting:

Abdominal pain:
Diarrhea:
Constipation:

7 Genitourinary

Dysuria:
Frequency:
Hematuria:
Incontinence:

8 Reproductive

Menstrual history:
Sexual function:
Pregnancy status:

9 Musculoskeletal

Joint pain:
Muscle pain:
Stiffness:

10 Skin

Rash:
Lesions:
Pruritus:

11 Neurologic

Headache:
Weakness:
Numbness:
Seizures:
Dizziness:

12 Psychiatric

Depression:
Anxiety:
Mood changes:

Sleep disturbance:

13 Endocrine

Heat intolerance:
Cold intolerance:
Polyuria:
Polydipsia:

14 Hematologic / Lymphatic

Easy bruising:
Bleeding:
Lymphadenopathy:

15 Allergic / Immunologic

Allergies:
Recurrent infections:

16 Additional

All other systems reviewed and negative unless otherwise noted:

Additional notes or positive findings not captured above...

Provider name & credentials:
Signature:
NPI:
Date / Time:
Facility:
Visit type: