# EMR CHARTING TEMPLATE

ELECTRONIC MEDICAL RECORD



## 1 Patient Information

### 1 PATIENT DETAILS

Name: _____ Date of Service: _____

DOB / Age: _____ Provider: _____

MRN: _____ Encounter Type: _____

## CC Chief Complaint

### 2 PRIMARY REASON FOR ENCOUNTER

Document the primary reason in the patient's own words — presenting complaint, duration...

## HPI History of Present Illness

### 3 ONSET, DURATION, LOCATION, CHARACTER, SEVERITY, TIMING, AGGRAVATING/RELIEVING, ASSOCIATED SYMPTOMS, PERTINENT NEGATIVES

## H Past History, Medications & Social

### 4a PAST MEDICAL HISTORY

Chronic illnesses, hospitalizations, ongoing issues...

### 4b PAST SURGICAL HISTORY

Prior surgeries, dates, complications...

### 4c MEDICATIONS & ALLERGIES

Current medications (dose/frequency if known)...

Allergies and reactions...

### 4d FAMILY & SOCIAL HISTORY

Hereditary conditions, first-degree relatives...

Tobacco / alcohol / substance / occupation / living...

## ROS Review of Systems

### 5 SYSTEM REVIEW

- ☐ Constitutional
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Gastrointestinal
- ☐ Genitourinary
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Psychiatric
- ☐ Other (specify): _____

## V Vitals

### V VITAL SIGNS

| | | | | | |
|---|---|---|---|---|---|
| Temperature: | | Blood Pressure: | | Heart Rate: | |
| Respiratory Rate: | | $SpO_2$: | | Weight: | |

## PE Physical Examination

### 6 EXAM FINDINGS

| | | | |
|---|---|---|---|
| General Appearance: | | HEENT: | |
| Cardiovascular: | | Respiratory: | |
| Abdomen: | | Musculoskeletal: | |
| Neurological: | | Skin: | |
| Psychiatric: | | | |

## O Orders & Results

### 7a ORDERS PLACED

Labs / imaging / medications / procedures / referrals...

### 7b RESULTS REVIEWED

Labs / imaging / other diagnostics...

## A Assessment

### 8 DIAGNOSES, DIFFERENTIAL, CLINICAL REASONING, RISK STRATIFICATION

## P Plan

### 9 MANAGEMENT

Medications / diagnostics / procedures / education / referrals...

## D Disposition & Follow-Up

### 10 OUTCOME

| | | | |
|---|---|---|---|
| Disposition: | | Follow-Up & Return Precautions: | |

### TIME DOCUMENTATION & BILLING

| | | | |
|---|---|---|---|
| Total Time: | | E/M Level: | |
| Counseling Time: | | Basis: | |
| Primary Dx Code: | | Secondary Dx Code(s): | |

| PROVIDER NAME | CREDENTIALS | DATE & TIME |
|---|---|---|
| | | |