

1 Patient Information

1 PATIENT DETAILS

Name:	_____	Date of Service:	_____
DOB / Age:	_____	Provider:	_____
MRN:	_____	Visit Type:	_____

CC Chief Complaint

2 PRIMARY REASON FOR VISIT

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

HPI History of Present Illness

3a ONSET, CONTEXT & DURATION

Onset & Context:	_____	Duration & Course:	_____
Location & Radiation:	_____	Character / Quality:	_____
Severity:	_____	Timing / Pattern:	_____
Aggravating Factors:	_____	Relieving Factors:	_____

3b ASSOCIATED SYMPTOMS & PERTINENT NEGATIVES

Document associated symptoms and explicit denials of key symptoms relevant to serious conditions...

ROS Review of Systems

4 SYSTEM REVIEW

<input type="checkbox"/> Constitutional	<input type="checkbox"/> Cardiovascular
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Gastrointestinal
<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Neurological	<input type="checkbox"/> Psychiatric
<input type="checkbox"/> Other (specify): _____	

V Vitals

V VITAL SIGNS

Temperature:	_____	Blood Pressure:	_____	Heart Rate:	_____
Respiratory Rate:	_____	SpO ₂ :	_____	Weight:	_____

PE Physical Examination

5a FOCUSED OR COMPREHENSIVE EXAM

General Appearance:	_____	HEENT:	_____
Cardiovascular:	_____	Respiratory:	_____
Abdomen:	_____	Musculoskeletal:	_____
Neurological:	_____	Skin:	_____
Psychiatric:	_____		_____

L Lab & Imaging

6a LABORATORY STUDIES

Key abnormal values and pertinent normals... _____

6b IMAGING STUDIES

X-ray, CT, MRI, ultrasound findings... _____

6c OTHER DIAGNOSTICS

ECG / POC tests: _____

A Assessment

7 DIAGNOSES, DIFFERENTIAL, CLINICAL REASONING, SEVERITY

Primary and secondary diagnoses, differential diagnoses, clinical reasoning, severity and acuity... _____

P Plan

8 MANAGEMENT STRATEGY

Medications / diagnostics / procedures / patient education / referrals / consultations... _____

F Follow-Up

9 NEXT STEPS

Timeframe & 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
