1 Patient Information

1 PATIENT DETAILS

Name: _____ Date of Examination: _____

DOB / Age: _____ Provider: _____

MRN: _____

1 General Appearance

1 OVERALL CONDITION & LEVEL OF DISTRESS

Appearance (well/ill/toxic/cachectic): _____ Level of Consciousness: _____

Hygiene & Grooming: _____ Posture & Interaction: _____

V Vitals

V VITAL SIGNS

Temperature: _____ Blood Pressure: _____ Heart Rate: _____

Respiratory Rate: _____ SpO_2: _____ Weight: _____

Pain Score (if applicable): _____

H HEENT & Neck

3 HEAD, EYES, EARS, NOSE, THROAT, NECK

Head (normocephalic, tenderness): _____ Eyes (PERRLA, EOM, conjunctiva): _____

Ears (canal, TM, erythema): _____ Nose (mucosa, septum, discharge): _____

Throat (mucosa, tonsils, pharynx): _____ Neck (ROM, lymphadenopathy, thyroid): _____

CV Cardiovascular & Respiratory

4a CARDIOVASCULAR

Heart Rate & Rhythm: _____ Heart Sounds (S1/S2/murmurs): _____

Peripheral Pulses: _____ Capillary Refill / Edema: _____

4b RESPIRATORY

Respiratory Effort: _____ Breath Sounds: _____

Chest Expansion: _____ Accessory Muscles: _____

AB Abdomen & Genitourinary

5a ABDOMEN

Inspection (distention, scars): _____ Palpation (tenderness, masses): _____

Bowel Sounds: _____ Organomegaly: _____

5b GENITOURINARY (AS INDICATED)

External findings / tenderness / device status: _____

MS Musculoskeletal & Neurological

6a MUSCULOSKELETAL

Range of Motion: _____ Strength & Tone: _____

Joint Swelling / Deformities: _____ Gait: _____

6b NEUROLOGICAL

Mental Status & Orientation: _____ Cranial Nerves: _____

Motor & Sensory Function: _____ Reflexes / Coordination: _____

SK Skin & Psychiatric

7a SKIN

Color / Temperature / Moisture: _____ Integrity (rashes, lesions, wounds): _____

Bruising / Discoloration: _____

7b PSYCHIATRIC

Mood & Affect: _____ Behavior & Cooperation: _____

A Assessment

8 KEY FINDINGS SUMMARY

Key physical findings, abnormalities, clinically significant normals...

P Plan

9 NEXT STEPS

Further diagnostics / treatment adjustments / monitoring / follow-up...

TIME DOCUMENTATION & BILLING

Total Time: _____ E/M Level: _____

Counseling Time: _____ Basis: _____

Primary Dx Code: _____ Secondary Dx Code(s): _____

PROVIDER NAME _____ CREDENTIALS _____ DATE & TIME _____