

1 PATIENT INFORMATION**1 PATIENT DETAILS**

NAME

DOB

AGE / SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

PRIMARY CARE PROVIDER

VISIT TYPE: NEW PATIENT / FOLLOW-UP / ANNUAL EXAM / SICK VISIT / CHRONIC DISEASE MANAGEMENT / TELEHEALTH

CARE SETTING: OUTPATIENT / FAMILY MEDICINE CLINIC / TELEHEALTH / URGENT VISIT

REFERRAL SOURCE, IF APPLICABLE

INTERPRETER USED, IF APPLICABLE

FAMILY MEMBER / CAREGIVER PRESENT, IF APPLICABLE

CC CHIEF COMPLAINT**2 PRIMARY REASON FOR VISIT**

Primary reason for the family medicine visit in the patient's own words — annual exam, preventive care, acute illness, chronic disease follow-up, medication refill, lab review, family health concern, reproductive health concern, pediatric or geriatric concern, mental health concern, lifestyle counseling, or care coordination...

S SUBJECTIVE**3 INTERVAL HISTORY & FAMILY-CENTERED CONTEXT****3a PRESENTING CONCERN**

Reason for visit (establishing care / annual wellness / acute complaint / chronic disease management / medication management / preventive screening / reproductive health / pediatric or adolescent care / geriatric care / post-hospital follow-up / family-centered coordination):

History of present illness (onset, duration, severity, frequency, progression, triggers, relieving factors, associated symptoms, prior episodes, exposures, home treatments tried, response, patient or family concerns):

3b CONDITIONS, MEDICATIONS & FAMILY CONTEXT

Chronic medical conditions and status (hypertension, diabetes, hyperlipidemia, asthma/COPD, thyroid, kidney disease, cardiovascular disease, obesity, chronic pain, mental health, autoimmune disease):

Family-centered context (household composition, caregiving responsibilities, family stressors, family illness patterns, support, intergenerational risk, factors affecting adherence or access):

Medication history and adherence (current medications, missed doses, side effects, refill needs, OTC medications, supplements, affordability, pharmacy access, medication organization):

Allergies (medication, food, latex, environmental, vaccine, contrast — with reaction type and severity):

3c LIFE-STAGE & PREVENTIVE HISTORY

Preventive care and screening history (blood pressure, diabetes, lipids, cancer screening, osteoporosis, infectious disease, depression, substance use, reproductive health):

Immunization history (vaccines due, vaccines received, records reviewed, hesitancy, contraindications, counseling):

Women’s / reproductive health, if applicable (menstrual history, pregnancy status, contraception, fertility, menopause symptoms, Pap/HPV, mammography, STI risk, postpartum or lactation concerns):

Men’s health, if applicable (urinary symptoms, sexual health, erectile concerns, prostate screening discussion, testicular concerns, fertility, cardiovascular risk counseling):

Pediatric / adolescent context, if applicable (growth, development, school performance, behavior, sleep, nutrition, screen time, immunization status, safety, sports participation, caregiver concerns):

Geriatric context, if applicable (function, falls, cognition, polypharmacy, hearing and vision, mobility, home safety,

caregiver support, advance care planning, goals of care):

3d BEHAVIORAL, FUNCTIONAL & SOCIAL HISTORY

Lifestyle and health behaviors (diet, exercise, sleep, hydration, caffeine, tobacco/nicotine, alcohol, substance use, sexual health, sun protection, injury prevention, safety practices):

Mental health (depression, anxiety, stress, sleep disturbance, trauma history, suicidal ideation, self-harm thoughts, substance use concerns, therapy, psychiatric medications, psychosocial stressors):

Functional status (ADLs/IADLs, mobility, exercise tolerance, falls, work or school limitations, caregiving needs, assistive devices, ability to manage medications and appointments):

Social history and social determinants (living situation, household, occupation, education, transportation, financial strain, food insecurity, housing stability, safety, IPV screening, social support, community resources):

Family history (cardiovascular disease, diabetes, cancer, hypertension, stroke, kidney disease, autoimmune disease, mental health conditions, substance use disorder, genetic conditions, sudden death, familial illness patterns):

Recent care and hospitalizations (emergency or urgent care visits, hospitalizations, surgeries, specialist visits, diagnostic testing, medication changes, pending follow-up):

Pertinent negatives (chest pain, severe dyspnea, syncope, neurologic deficit, severe abdominal pain, uncontrolled bleeding, fever with systemic illness, suicidal or homicidal ideation, pregnancy-related red flags, rapidly worsening symptoms):

ROS FAMILY MEDICINE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Constitutional — fever, chills, fatigue, appetite change, weight change

HEENT — headache, vision or hearing change, congestion, sore throat, dental concerns

Cardiovascular — chest pain, palpitations, edema, dizziness, syncope

Respiratory — cough, wheezing, dyspnea, sleep apnea symptoms

Gastrointestinal — abdominal pain, nausea, vomiting, diarrhea, constipation, reflux, blood in stool

Genitourinary — dysuria, frequency, hematuria, incontinence, pelvic, sexual, menstrual or pregnancy-related symptoms

Musculoskeletal — joint pain, back pain, muscle pain, swelling, injury, mobility limitation

Skin — rash, lesions, wounds, itching, changing moles

Neurologic — weakness, numbness, tingling, headache, tremor, dizziness, seizures, cognitive concerns

Psychiatric — depression, anxiety, sleep disturbance, stress, suicidal ideation, substance use

Endocrine / metabolic — heat or cold intolerance, polyuria, polydipsia, weight change, glucose concerns

O

OBJECTIVE

5

OBSERVED FINDINGS

V

VITALS

TEMPERATURE

BLOOD PRESSURE

HEART RATE

RESPIRATORY RATE

OXYGEN SATURATION

HEIGHT

WEIGHT

BMI

PAIN SCORE, IF APPLICABLE

General appearance (alertness, distress level, body habitus, hygiene, mobility, interaction with family or caregiver, overall condition):

HEENT (conjunctiva, sclera, pupils, extraocular movements, tympanic membranes, ear canals, nasal and oral mucosa, dentition, pharynx, tonsils, sinus tenderness):

Neck (range of motion, lymphadenopathy, thyroid enlargement or nodules, carotid bruits, masses, tenderness):

Cardiovascular (rate, rhythm, murmurs, rubs, gallops, pulses, capillary refill, edema, perfusion):

Pulmonary (respiratory effort, breath sounds, wheezes, crackles, rhonchi, cough, oxygen requirement, work of breathing):

Abdomen (bowel sounds, tenderness, distension, guarding, rebound, masses, hepatosplenomegaly, hernia, surgical scars):

Genitourinary / breast / pelvic / rectal, if assessed (findings, chaperone use, exam limitations, patient tolerance):

Musculoskeletal (range of motion, tenderness, swelling, deformity, strength, gait, joint and spine findings, mobility):

Skin (rashes, lesions, wounds, bruising, edema, color changes, suspicious lesions, infection signs):

Neurologic (mental status, cranial nerves, strength, sensation, reflexes, coordination, gait, focal deficits, tremor, cognitive screening):

Psychiatric (mood, affect, behavior, speech, thought process, insight, judgment, safety concerns):

PC

PREVENTIVE CARE / HEALTH MAINTENANCE

6

NEEDS & COMPLETED ITEMS

AGE-APPROPRIATE CANCER SCREENINGS

DIABETES SCREENING

DEPRESSION & ANXIETY SCREENING

INFECTIOUS DISEASE SCREENING

IMMUNIZATIONS DUE OR ADMINISTERED

OSTEOPOROSIS SCREENING, IF APPLICABLE

PEDIATRIC GROWTH / DEVELOPMENT SCREENING, IF APPLICABLE

LIFESTYLE COUNSELING PROVIDED (NUTRITION / PHYSICAL ACTIVITY / SLEEP / TOBACCO CESSATION / ALCOHOL MODERATION / INJURY PREVENTION / SAFETY)

BLOOD PRESSURE SCREENING

LIPID SCREENING

TOBACCO, ALCOHOL & SUBSTANCE USE SCREENING

SEXUAL & REPRODUCTIVE HEALTH SCREENING

DENTAL AND VISION CARE

FALL RISK SCREENING, IF APPLICABLE

ADVANCE CARE PLANNING, IF APPLICABLE

7 SCORES, INTERPRETATION & COMPARISON

PHQ-2 / PHQ-9

GAD-7

AUDIT-C

DAST / CAGE-AID

MINI-COG / COGNITIVE SCREENING

FALL RISK SCREENING

PAIN SCALE

ASCVD RISK ESTIMATE

SOCIAL DETERMINANTS OF HEALTH SCREENING

INTIMATE PARTNER VIOLENCE SCREENING

DEVELOPMENTAL SCREENING, IF APPLICABLE

CONDITION-SPECIFIC SCREENING TOOLS

8 REVIEWED OR ORDERED

Routine labs (CBC, CMP, lipid panel, HbA1c, fasting glucose, TSH, urinalysis, urine microalbumin, vitamin levels, iron studies, pregnancy testing when appropriate):

Infectious disease testing (COVID-19, influenza, strep, RSV, HIV, hepatitis, STI, TB screening, urine culture):

Imaging (X-ray, ultrasound, CT, MRI, mammogram, DEXA, echocardiogram):

Cardiac / pulmonary testing (EKG, Holter monitor, pulmonary function testing, sleep study, stress test):

Preventive screening results (Pap/HPV, colonoscopy, FIT/Cologuard, PSA if discussed, mammogram, DEXA, lead screening if applicable):

Prior records reviewed (specialist notes, hospital and emergency records, medication and immunization history, preventive screening records, lab trends, imaging reports, family records, outside records):

9 FAMILY MEDICINE CLINICAL INTERPRETATION

Primary diagnosis or working diagnosis. Differential diagnoses for acute complaints. Chronic condition status — controlled, uncontrolled, stable, improving or worsening. Preventive care gaps and screening needs. Family history and family-centered risk considerations. Medication adherence, response, side effects and refill needs. Lifestyle factors and social determinants affecting care. Mental health, safety, caregiver or family support concerns. Pediatric, reproductive, adult or geriatric considerations. Need for labs, imaging, medications, referrals, preventive screening, care coordination, family education, follow-up or a higher level of care...

P

PLAN

10 FAMILY MEDICINE MANAGEMENT BY PROBLEM

Acute issue plan (treatment, supportive care, diagnostic testing, expected course, return precautions). Chronic disease management (medication changes, monitoring, lifestyle counseling, lab follow-up, self-management goals, specialist coordination). Medication plan. Preventive care plan (screenings, vaccines, counseling, follow-up). Family-centered plan (caregiver involvement, household health education, family risk counseling, support resources, coordination). Lifestyle plan. Mental health plan (screening results, therapy referral, medication, crisis resources, safety planning). Reproductive or sexual health plan (contraception, pregnancy testing, STI testing, menstrual concerns, menopause care, fertility counseling). Pediatric or geriatric plan. Diagnostic plan. Referral and care coordination. Patient and family education, and when to seek urgent or emergency care...

F

FOLLOW-UP

11 REASSESSMENT PLAN

Follow-up timeframe and purpose (symptom reassessment, chronic disease monitoring, medication response, lab or imaging review, preventive care completion, referral follow-through, annual exam, family or caregiver education follow-up, urgent return precautions):

TB

TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

COUNSELING / PREVENTIVE COUNSELING TIME

FAMILY / CAREGIVER COUNSELING TIME

CARE COORDINATION TIME

RECORDS REVIEW TIME

MEDICATION MANAGEMENT TIME

E/M LEVEL: 99202 / 99203 / 99204 / 99205 / 99212 / 99213 / 99214 / 99215

PREVENTIVE VISIT CODE, IF APPLICABLE

SCREENING CODE(S), IF APPLICABLE

IMMUNIZATION ADMINISTRATION CODE(S)

PROCEDURE CODE(S), IF APPLICABLE

CHRONIC CARE MANAGEMENT CODE(S)

BASIS FOR BILLING: TIME-BASED / MEDICAL DECISION MAKING / PREVENTIVE CARE / SCREENING / PROCEDURE-BASED / CARE COORDINATION

PRIMARY ICD-10 CODE

SECONDARY ICD-10 CODE(S)

SO

PROVIDER SIGN-OFF

PROVIDER NAME

CREDENTIALS

SPECIALTY: FAMILY MEDICINE

DATE

TIME