

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 / HOSPITAL FOLLOW-UP / TELEHEALTH

CARE SETTING: OUTPATIENT / INTERNAL MEDICINE CLINIC / INPATIENT FOLLOW-UP / TELEHEALTH / URGENT VISIT

REFERRAL SOURCE, IF APPLICABLE

INTERPRETER USED, IF APPLICABLE

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

Primary internal medicine-related reason for the visit in the patient's own words — acute symptoms, chronic disease follow-up, medication management, hospital follow-up, lab review, preventive care, cardiometabolic risk management, multisystem complaint, diagnostic evaluation, or care coordination...

S SUBJECTIVE**3 INTERVAL HISTORY & CHRONIC DISEASE STATUS****3a PRESENTING CONCERN**

Reason for visit (establishing care / annual exam / acute complaint / chronic disease management / medication reconciliation / post-hospital follow-up / diagnostic evaluation / lab or imaging review / preventive screening / specialist coordination / multiple comorbidities):

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

Chronic medical conditions and status (hypertension, diabetes, hyperlipidemia, CAD, heart failure, CKD, COPD/asthma, thyroid, liver disease, anemia, obesity, chronic pain, autoimmune, neurologic, psychiatric):

3b SYSTEM-BASED REVIEW

Cardiovascular symptoms and risk factors (chest pain, palpitations, dyspnea, edema, dizziness, syncope, exercise tolerance, blood pressure and lipid trends, diabetes status, tobacco use, family history, ASCVD risk):

Respiratory symptoms (cough, wheezing, dyspnea, sputum, hemoptysis, sleep apnea symptoms, inhaler use, oxygen use, tobacco exposure, infection symptoms):

Gastrointestinal / hepatic symptoms (abdominal pain, nausea, vomiting, diarrhea, constipation, reflux, dysphagia, blood in stool, jaundice, liver disease history, alcohol use, bowel pattern):

Genitourinary symptoms (dysuria, frequency, urgency, hematuria, incontinence, nocturia, stone history, renal disease, sexual health, pelvic or prostate symptoms):

Endocrine / metabolic symptoms (polyuria, polydipsia, weight change, heat or cold intolerance, glucose trends, thyroid symptoms, osteoporosis risk, obesity-related concerns, medication metabolic effects):

Neurologic symptoms (headache, dizziness, weakness, numbness, tingling, tremor, memory concerns, gait change, falls, seizures, stroke or TIA symptoms, neuropathy):

Musculoskeletal / pain symptoms (joint, muscle or back pain, stiffness, swelling, injury, chronic pain status, mobility limitation, functional impairment, treatment response):

Mental health and sleep (mood, anxiety, stress, sleep quality, insomnia, sleep apnea symptoms, cognitive concerns, substance use, suicidal ideation, therapy, psychiatric medications):

3c MEDICATIONS, PREVENTIVE CARE & SOCIAL HISTORY

Medication history and reconciliation (current medications, adherence, missed doses, side effects, changes, refills, OTC medications, supplements, anticoagulants, controlled substances, affordability and access):

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

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

Preventive care and screening history (cancer screening, cardiovascular and diabetes screening, lipids, osteoporosis, infectious disease, depression, substance use, immunization status):

Lifestyle and health behaviors (diet, exercise, sleep, hydration, caffeine, tobacco/nicotine, alcohol, substance use, sexual health, occupational exposures, travel, safety, readiness for change):

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

Social history and social determinants (living situation, household, occupation, transportation, financial strain, food insecurity, housing stability, health literacy, safety, social support, access barriers):

Family history (cardiovascular disease, diabetes, cancer, hypertension, stroke, kidney disease, liver disease, autoimmune disease, neurologic disease, psychiatric conditions, substance use disorder, genetic conditions, sudden death):

Pertinent negatives (chest pain, severe dyspnea, syncope, focal neurologic deficit, severe abdominal pain, GI bleeding, uncontrolled bleeding, fever with systemic illness, suicidal or homicidal ideation, rapidly worsening symptoms):

ROS INTERNAL MEDICINE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

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

HEENT — headache, vision or hearing change, congestion, sore throat, dysphagia

Cardiovascular — chest pain, palpitations, edema, dyspnea on exertion, dizziness, syncope

Respiratory — cough, wheezing, shortness of breath, sputum, hemoptysis, sleep apnea symptoms

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

Genitourinary — dysuria, frequency, hematuria, incontinence, nocturia, pelvic or sexual health concerns

Musculoskeletal — joint pain, back pain, muscle pain, swelling, stiffness, injury

Skin — rash, lesions, wounds, itching, bruising, color changes

Neurologic — weakness, numbness, tingling, headache, tremor, dizziness, gait change, memory concern, seizures

Psychiatric — depression, anxiety, insomnia, stress, suicidal ideation, substance use

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

Hematologic — bleeding, bruising, anemia symptoms, lymph node swelling, anticoagulation concerns

O

OBJECTIVE

5

OBSERVED FINDINGS

V

VITALS

TEMPERATURE

BLOOD PRESSURE

HEART RATE

RESPIRATORY RATE

OXYGEN SATURATION

HEIGHT

WEIGHT

BMI

PAIN SCORE, IF APPLICABLE

ORTHOSTATIC VITALS, IF OBTAINED

General appearance (alertness, distress level, body habitus, hygiene, nutritional appearance, mobility, overall condition):

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

Abdomen (bowel sounds, tenderness, distension, guarding, rebound, masses, hepatosplenomegaly, ascites, hernia, bruits)

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

CHRONIC DISEASE / RISK ASSESSMENT

HEART DISEASE OR HEART FAILURE STABILITY

THYROID DISEASE CONTROL

ANEMIA OR HEMATOLOGIC STATUS

CORD / ASTHMA CONTROL & INHALED USE

LIVER DISEASE STATUS

OBESITY, NUTRITION & METABOLIC RISK

OBESITY NUTRITION & METABOLIC RISK

MENTAL HEALTH & SUBSTANCE USE RISK

FALLS, COGNITION, FRAILTY OR FUNCTIONAL DECLINE

MEDICATION BURDEN, POLYPHARMACY & HIGH-RISK MEDICATIONS

PC

PREVENTIVE CARE / HEALTH MAINTENANCE

7 NEEDS & COMPLETED ITEMS

AGE-APPROPRIATE CANCER SCREENINGS

BLOOD PRESSURE SCREENING

DIABETES SCREENING

LIPID SCREENING

DEPRESSION & ANXIETY SCREENING

TOBACCO, ALCOHOL & SUBSTANCE USE SCREENING

INFECTIOUS DISEASE SCREENING

IMMUNIZATIONS DUE OR ADMINISTERED

OSTEOPOROSIS SCREENING, IF APPLICABLE

FALL RISK SCREENING, IF APPLICABLE

DENTAL, VISION & HEARING CARE

ADVANCE CARE PLANNING, IF APPLICABLE

LIFESTYLE COUNSELING PROVIDED (NUTRITION / PHYSICAL ACTIVITY / SLEEP / TOBACCO CESSATION / ALCOHOL MODERATION / WEIGHT MANAGEMENT / SAFETY)

ST

SCREENING / ASSESSMENT TOOLS

8 SCORES, INTERPRETATION & COMPARISON

PHQ-2 / PHQ-9

GAD-7

AUDIT-C

DAST / CAGE-AID

MINI-COG / MOCA

FALL RISK SCREENING

PAIN SCALE

ASCVD RISK ESTIMATE

STOP-BANG / SLEEP APNEA SCREENING

SOCIAL DETERMINANTS OF HEALTH SCREENING

INTIMATE PARTNER VIOLENCE SCREENING

CONDITION-SPECIFIC SCREENING TOOLS

L

LABORATORY AND DIAGNOSTIC RESULTS

9 REVIEWED OR ORDERED

Routine labs (CBC, CMP, lipid panel, HbA1c, fasting glucose, TSH, urinalysis, urine microalbumin, vitamin levels, iron studies, B12, folate, inflammatory markers, coagulation studies):

Cardiometabolic testing (A1c and lipid trends, ASCVD risk, renal and liver function, electrolytes, urine albumin-creatinine ratio, EKG, stress testing, vascular testing):

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

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

Pulmonary / sleep testing (pulmonary function testing, sleep study, overnight oximetry, chest imaging):

Preventive screening results (colonoscopy, FIT/Cologuard, Pap/HPV, mammogram, PSA if discussed, DEXA, lung cancer screening, AAA screening):

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

A ASSESSMENT

10 INTERNAL MEDICINE CLINICAL INTERPRETATION

Primary diagnosis or working diagnosis. Differential diagnoses for acute or multisystem complaints. Chronic disease status — controlled, uncontrolled, stable, improving, worsening or requiring further evaluation. Severity and acuity of current illness. Cardiometabolic, renal, hepatic, pulmonary, neurologic, psychiatric or geriatric risk factors. Preventive care gaps. Medication adherence, response, side effects, interactions and refill needs. Polypharmacy or high-risk medication concerns. Lifestyle factors and social determinants. Functional status, safety, cognition or care support concerns. Need for labs, imaging, medication changes, referrals, preventive screening, care coordination, close follow-up or a higher level of care...

P PLAN

11 INTERNAL MEDICINE MANAGEMENT BY PROBLEM

Acute issue plan (treatment, supportive care, diagnostic testing, expected course, return precautions). Chronic disease management (medication changes, monitoring, self-management goals, lifestyle counseling, lab follow-up, specialist coordination). Medication management (initiation, continuation, dose adjustment, discontinuation, refills, side effects, interactions, reconciliation, affordability, adherence counseling). Preventive care plan. Cardiometabolic risk plan (blood pressure, diabetes, lipids, weight, smoking cessation, exercise, nutrition, ASCVD risk reduction). Diagnostic plan. Mental health plan. Functional and safety plan (fall prevention, mobility support, cognitive evaluation, home safety, caregiver support, advance care planning). Lifestyle plan. Referral and care coordination. Patient education and when to seek urgent or emergency care...

F

FOLLOW-UP

12 REASSESSMENT PLAN

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

TB

TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

COUNSELING / PREVENTIVE COUNSELING TIME

CARE COORDINATION TIME

RECORDS REVIEW TIME

MEDICATION MANAGEMENT TIME

HOSPITAL RECORDS / DISCHARGE REVIEW TIME

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

PREVENTIVE VISIT CODE, IF APPLICABLE

TRANSITIONAL CARE MANAGEMENT CODE(S)

CHRONIC CARE MANAGEMENT CODE(S)

SCREENING CODE(S), IF APPLICABLE

IMMUNIZATION ADMINISTRATION CODE(S)

PROCEDURE CODE(S), IF APPLICABLE

BASIS FOR BILLING: TIME-BASED / MEDICAL DECISION MAKING / PREVENTIVE CARE / TRANSITIONAL CARE / CHRONIC DISEASE MANAGEMENT / PROCEDURE-BASED

PRIMARY ICD-10 CODE

SECONDARY ICD-10 CODE(S)

SO

PROVIDER SIGN-OFF

PROVIDER NAME

CREDENTIALS

SPECIALTY: INTERNAL
MEDICINE

DATE

TIME