

NEW PATIENT

Name: _____ DOB _____ Date _____ Referring Doctor: _____

Allergies: _____

Chief complaint & reason for visit today _____

History of present illness: (Location, Quality, Timing, Severity, Duration, Context, Modifying Factors, Assoc. signs/symptoms) (1-3 brief, 4+ extended)

MEDICATIONS:

REVIEW OF SYSTEMS:

1. Constitution	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Appetite	<input type="checkbox"/> Other _____	
2. G.I.	YES	NO	6. Genitourinary	YES	NO
-Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	-Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
-Nausea	<input type="checkbox"/>	<input type="checkbox"/>	-Frequency	<input type="checkbox"/>	<input type="checkbox"/>
-Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	-Burning Urine	<input type="checkbox"/>	<input type="checkbox"/>
-Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	-Other _____		
-Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	7. Neurological	YES	NO
-Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	-Headaches	<input type="checkbox"/>	<input type="checkbox"/>
-Constipation	<input type="checkbox"/>	<input type="checkbox"/>	-Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
-Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	-Seizure	<input type="checkbox"/>	<input type="checkbox"/>
-Tarry black stools	<input type="checkbox"/>	<input type="checkbox"/>	-Change in mental status	<input type="checkbox"/>	<input type="checkbox"/>
-Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	-Other _____		
-Other _____			8. Musculoskeletal	YES	NO
3. HEENT	YES	NO	-Joint pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>
-Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	-History of arthritis	<input type="checkbox"/>	<input type="checkbox"/>
-Headaches	<input type="checkbox"/>	<input type="checkbox"/>	-Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>
-Hearing abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	-Other _____		
-Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	9. GYN & OB History	YES	NO
-Vertigo/dizziness	<input type="checkbox"/>	<input type="checkbox"/>	-LMP _____		
-Other _____			-Last mammogram _____		
4. Respiratory	YES	NO	-Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
-Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	-Birth control	<input type="checkbox"/>	<input type="checkbox"/>
-Cough expectoration	<input type="checkbox"/>	<input type="checkbox"/>	-Other _____		
-Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	10. Skin	YES	NO
-Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	-Rash	<input type="checkbox"/>	<input type="checkbox"/>
-Other _____			-Abnormal moles	<input type="checkbox"/>	<input type="checkbox"/>
5. Cardiovascular	YES	NO	-Other _____		
-Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	All other systems negative _____		
-Palpitations	<input type="checkbox"/>	<input type="checkbox"/>			
-History of murmur	<input type="checkbox"/>	<input type="checkbox"/>			
-Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>			
-Other _____					

Past History:

<input type="checkbox"/> Hypertension (high blood pressure)	<input type="checkbox"/> Hypothyroidism/Hyperthyroidism/goiter
<input type="checkbox"/> Coronary artery disease/heart attack/CHF	<input type="checkbox"/> Cardiac arrhythmia
<input type="checkbox"/> Emphysema/chronic bronchitis/asthma/hayfever/eczema	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Peptic ulcers (duodenal/gastric)	<input type="checkbox"/> Anemia
<input type="checkbox"/> Stroke/Seizure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Cancer	<input type="checkbox"/> Other _____

Previous Surgeries/Dates:

<input type="checkbox"/> Coronary bypass _____
<input type="checkbox"/> Appendix _____
<input type="checkbox"/> Gallbladder _____
<input type="checkbox"/> Colon _____
<input type="checkbox"/> Stomach/Abdominal _____
<input type="checkbox"/> Other _____

What is your Social History?

Do you smoke? _____ How many packs a day? _____ For how many years? _____
 Do you drink alcohol? _____ How many drinks per day? _____ per week? _____ per month? _____
 Do you use illicit drugs? _____ If yes, what kind? _____

What is the Health Status of Your Family?

Mother: _____ Father: _____ Children: _____
 Brother(s): _____ Sister(s): _____

EXAM

1. **Constitution** BP _____ Pulse _____ Height _____ Weight _____ Temp. _____

Appearance: Well Developed Ill-Appearing Cachectic

2. **Eyes** **NORMAL ABNORMAL**
-Conjunctivae and lid _____
-Pupils and irises _____
-Other _____

3. **Ears/Nose/Mouth/Throat** **NORMAL ABNORMAL**
-Teeth, gums, lips _____
-External inspection of ears & nose _____
-Throat _____
-Other _____

4. **Neck** **NORMAL ABNORMAL**
-Neck exam _____
-Thyroid exam _____
-Lymph node exam _____
-Other _____

5. **Respiratory** **NORMAL ABNORMAL**
-Percussion of chest _____
-Auscultation/breath sounds Clear _____
-Other _____

6. **Cardiovascular** **YES NO**
-Heart sounds normal _____
-Pedal pulses present _____
-Extremity edema absent _____
-Varicosities absent _____
-Other _____

7. **Gastrointestinal** **YES NO**
-Bowel sounds normal _____
-Tenderness/masses absent _____
-Hepatosplenomegaly absent _____
-Hernia absent _____
-Jaundice absent _____
-Ascites absent _____
-Anus and rectum normal _____
 Pt. refused Pt. deferred
-Obtain stool sample _____
-Other _____

8. **Musculoskeletal** **NORMAL ABNORMAL**
-Gait w/notation of ability _____
-Assessment of muscle strength and tone _____
-Joint swelling absent YES NO _____
-Joint deformities absent YES NO _____
-Other _____

9. **Skin** **NORMAL ABNORMAL**
-Inspect skin and SC tissue _____
-Rash absent YES NO _____
-Abnormal moles absent YES NO _____
-Other _____

10. **Neurological** **YES NO**
-Dementia absent _____
-Paresis/paralysis absent _____
-Reflexes normal _____
-Other _____

11. **Psychiatric** **YES NO**
-Orientation normal (person, place, time) _____
-Mood & affect normal (depressed/anxious, etc.) _____
-Other _____

(99201 = 1-5 bullets, 99202 = 6 bullets, 99203 = 2 bullets in 6 areas/systems, 99204/99205 = 2 bullets in 9 areas/symptoms)

IMPRESSION/PLAN

Risks, alternative treatment modalities, complications of procedure and missing polyps and/or cancer discussed in detail with the patient.
Face-to face time with patient _____ Time spent in counseling and/or coordination of care _____
Next Appointment _____ Provider Signature _____