ESTABLISHED 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:

Status of chronic or inactive condition and any change to ROS or PFSH since last visit?

REVIEW OF SYSTEMS:

1. Constitution ☐ Fatigue ☐ Weight loss/gain ☐ Appetite ☐ Other _____

2. G.I.	**YES**	**NO**	
-Abdominal pain	☐	☐	_____
-Nausea	☐	☐	_____
-Vomiting	☐	☐	_____
-Heartburn	☐	☐	_____
-Difficulty swallowing	☐	☐	_____
-Diarrhea	☐	☐	_____
-Constipation	☐	☐	_____
-Rectal bleeding	☐	☐	_____
-Tarry black stools	☐	☐	_____
-Jaundice	☐	☐	_____
-Other _____			

3. HEENT	**YES**	**NO**	
-Thyroid problems	☐	☐	_____
-Headaches	☐	☐	_____
-Hearing abnormalities	☐	☐	_____
-Post nasal drip	☐	☐	_____
-Vertigo/dizziness	☐	☐	_____
-Other _____			

4. Respiratory	**YES**	**NO**	
-Shortness of breath	☐	☐	_____
-Cough expectoration	☐	☐	_____
-Coughing blood	☐	☐	_____
-Wheezing	☐	☐	_____
-Other _____			

5. Cardiovascular	**YES**	**NO**	
-Chest pain	☐	☐	_____
-Palpitations	☐	☐	_____
-History of murmur	☐	☐	_____
-Leg swelling	☐	☐	_____
-Other _____			

6. Genitourinary	**YES**	**NO**	
-Bleeding	☐	☐	_____
-Frequency	☐	☐	_____
-Burning Urine	☐	☐	_____
-Other _____			

7. Neurological	**YES**	**NO**	
-Headaches	☐	☐	_____
-Dizziness	☐	☐	_____
-Seizure	☐	☐	_____
-Change in mental status	☐	☐	_____
-Other _____			

8. Musculoskeletal	**YES**	**NO**	
-Joint pain/stiffness	☐	☐	_____
-History of arthritis	☐	☐	_____
-Leg cramps	☐	☐	_____
-Other _____			

9. GYN & OB History	**YES**	**NO**	
-LMP _____			
-Last mammogram _____			
-Abnormal bleeding	☐	☐	_____
-Birth control	☐	☐	_____
-Other _____			

10. Skin	**YES**	**NO**	
-Rash	☐	☐	_____
-Abnormal moles	☐	☐	_____
-Other _____			

All other systems negative _____

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 _____