

Date of Service / / Time of Service : AM PM

Is this a consultation? Yes No If yes, name and address of requesting physician

IMPORTANT REMINDER: Consultations include a written reply to the requesting physician!

CHIEF COMPLAINT (CC)--Reason for patient's visit today

HISTORY - COMPLETED BY PROVIDER

History of Present Illness (Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated signs/symptoms)

OR Status of Chronic or Inactive Conditions (3 or more = extended w/o HPI)

(1-3 brief, 4+ extended)

REVIEW OF SYSTEMS (ROS)/PAST MEDICAL, FAMILY, AND SOCIAL HISTORY (PFSH)

See Patient Health Questionnaire dated (mm/dd/yyyy) for additional ROS and PFSH.

Provider Comments - Review of systems

Is the patient having any current problems, signs, or symptoms in any of the following areas? (Provider MUST comment on all "Yes" responses.)

- YES NO YES NO
Constitutional Integumentary (Skin and Breast)
Eyes Neurological
Ears, Nose, Throat Psychiatric
Cardiovascular Endocrine
Respiratory Hematologic/Lymphatic
Gastrointestinal Allergy/Immunology
Genitourinary Other
Musculoskeletal Other

Medications (prescription, O-T-C, vitamins, herbals--include oral, eye drops, ear drops, nose drops, suppositories, skin lotions and creams used on a regular basis)

Last Menstrual Period (mm/dd/yyyy)

All other systems reviewed and negative

Review of Systems : 1 problem pertinent, 2-9 extended, 10+ complete

Previous Surgeries/Dates:

Allergies

What is patient's Social History? Marital Status (circle one): Divorced Domestic Partnered Married Single Widowed
Who lives with the patient? Current Employer Patient's Occupation
Does patient smoke? Cigarettes (# of packs/day) Cigars (# of cigars/day) Pipe (# of bowls/day) For how many years?
Does patient drink alcohol? How many drinks? per day per week per month
Does patient use illicit drugs? If yes, what kind? How often?
Is patient sexually active? Yes No Does patient use condoms? (circle one) Always Sometimes Never
Other contraceptive use? Yes No If yes, what kind?
Other high risk behavior? Yes No If yes, describe

What is the Health Status of the Patient's Family?
Mother: Father:
Grandparents: Brothers/Sisters:
Family Illnesses:
History of Heart Disease (heart attack, heart failure) yes no
History of strokes? yes no History of high blood pressure? yes no History of diabetes? yes no

Street Address, Suite Number
City, State, Zip+4

Logo Placement



Date of Service / /

EXAM

When this box is checked, more than fifty percent (50%) of this service was time spent counseling the patient and/or coordinating patient care.
 Total Time of Visit _____ Time Spent in Counseling _____
 Details of counseling and/or coordination of care MUST be documented below!

IMPRESSION

PLAN

RESIDENT'S/FELLOW'S SIGNATURE
 (include credentials, i.e., M.D., D.O., and PGY status)

↓ DATE ↓ ↓ TIME ↓

AM
 PM

TEACHING PHYSICIAN DOCUMENTATION Additional documentation of teaching physician:

PATH (PHYSICIANS AT TEACHING HOSPITALS) STATEMENTS--Check ONLY the box that is applicable!

I was present with Dr. _____ (Name of Resident/Fellow) during the history and exam. I discussed the case with the resident/fellow and agree with the findings and plan as documented in the resident's/fellow's note except as noted.

I saw and evaluated the patient. I discussed the case with Dr. _____ (Name of Resident/Fellow) and agree with the resident's/fellow's findings and plan as documented in the resident's/fellow's note except as noted.

PROVIDER'S SIGNATURE
 (include credentials, i.e., M.D., D.O.)

↓ DATE ↓ ↓ TIME ↓

AM
 PM

PROVIDER'S SIGNATURE--LATE ENTRY (if applicable)
 (include credentials, i.e., M.D., D.O.)

↓ DATE ↓ ↓ TIME ↓

AM
 PM

Street Address, Suite Number
 City, State, Zip+4

**Logo
 Placement**

NEW PATIENT or CONSULTATION FORM
 Name of Department
 Page 2 of 2 Form ##### Original Form mm/yyyy

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