

NAME _____ DOCTOR _____ NURSE _____ ALL MLC
 See chart info sheet
 AGE _____ HT _____ WT _____ BP _____ P _____ R _____ T _____ Oral Ax Rectal

DATE: _____ Immun - UTD Alcohol _____ Smoker No _____ ppd, Advised to quit

History:

Past NC, MLC, ALL, hspt, surg, immun

Family NC

Social NC, Smoke, ETOH, occupation, marital
 Updated since _____ Last visit
 See Chart Info Sheet

PHYSICIANS REVIEW

- Problem List History Form
- Nursing Notes PT / RT / OT
- Flow Sheet Consult
- Case Management

MDM

- Req/Review lab/xray/EKG/tests
- Req/Review tests w/testing physician
- Direct vis. Or interp of test done by other physician
- Decision to obtain old / additional records
- Review old / additional records

CC:

	ROS	nl	See note
Const	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT/mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin/breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psych	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hem/Lymph	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allerg/Immun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- All other systems (-)
- No change since _____

Couns/coord > 50%
 Total Time: _____ min.
 Couns / Coord time: _____ min.

EXAM: Circled if abnormal, Checked if normal

- General Appearance** **Three VS**
- Conjunctiva and lid - INSP
- Pupils and Irises – EX Optic disc
- External Ear and Nose - INSP**
- EAC & TM – EX** **Hearing**
- Nasal mucosa and septum - INSP**
- Oropharynx EX** **Lips teeth gums**
- Neck – EX Thyroid - EX
- Lymph nodes of** Neck Axilla Groin
- Resp. effrt – ASSMT Percuss Lung
- Lungs auscultation Palp Chest
- Heart auscultation** **Palp Heart**
- Extremities for edema/varicosities**
- Pedal pulses** **Carotid AA**
 Femoral Arteries **Abd. Aorta**
- Abdomen – EX for masses or tenderness
- Liver & Spl – EX Rectal Heme
- Hernia – EX
- Skin & SubQ tissue - INSP**
- Skin & SubQ tissue - PALP**
- Cranial Nerves II – XII DTR's - EX
- Sensation - EX
- Orientation to person, place, & time**
- Mood & Affect** **Memory** **Judgement & Insight**

I certify that I have reviewed the documentation contained in this clinical record and that it is accurately recorded.

 Physician Signature