

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