

Patient: Richard Hayes Date: 11/24/09

Initial Hospital Care

3 out of 3 Key Components Required				
E/M	Hx	Exam	MDM	Time
99221	Det	Det	SF/Low	30
99222	Comp	Comp	Mod	50
99223	Comp	Comp	High	70

Chief Complaint: SOB

HPI Brief: 1 - 3 HPI elements* Extended: 4 HPI elements* or status of 3 problems

c/o intermittent SOB exacerbated by exertion which began yesterday. Associated w/ lower extremity edema.

*HPI Elements: Location, Quality, Timing, Severity, Duration, Context, Modifying Factors, Associated Signs and Symptoms

Past Medical, Family and Social History

PMH CAD, COPD, HTN, DM, TIA
 FH 57 m/f, 72 m/f. 3 kids 1BH
 SH ☉ tobacco ☉ eth. Retired

Levels of History

Problem Focused: Brief HPI, no ROS/PFSH EPF: Brief HPI, 1 ROS, no PFSH
 Detailed: Ext HPI, 2 - 9 ROS, 1/3 PFSH Comp: Ext HPI, 10 ROS, 3/3 PFSH

Data Reviewed

136/101/24 4-9/30/14 8/34/245 CR was reviewed = (-)
1st Hxate some COP
EXG = NSR 45TΔS

Data Points

Review and/or order labs	Review and/or order X-rays	Review and/or order medical test (PFTs, EKG, echo, cath)	Discuss test with MD	Review any image, tracing, specimen	Order old records	Summarize old records
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physical Exam		Abnormal Findings
CONSTITUTIONAL		
Record three vital signs	yes no	
<u>76/80, 72, 98</u>	<input checked="" type="checkbox"/>	
Conversant/NAD	yes no	
<input checked="" type="checkbox"/>		
EYES		
Pink conjunctivae; no ptosis	yes no	
<input checked="" type="checkbox"/>		
PERRLA		
Fundi clear, no AV nicking	yes no	
<input checked="" type="checkbox"/>		
ENMT		
Nose and ears appear normal	yes no	
<input checked="" type="checkbox"/>		
Good dentition		
No pharyngeal erythema	yes no	
<input checked="" type="checkbox"/>		
NECK		
Non-tender, no masses	yes no	
<input checked="" type="checkbox"/>		
No thyromegaly or nodules	yes no	
<input checked="" type="checkbox"/>		
RESPIRATORY		
Normal respiratory effort	yes no	
<input checked="" type="checkbox"/>		
Clear to auscultation	yes no	
<input checked="" type="checkbox"/>		
Clear to percussion	yes no	
<input checked="" type="checkbox"/>		
CARDIOVASCULAR		
No carotid bruits	yes no	
<input checked="" type="checkbox"/>		
RRR, no MRGs	yes no	
<input checked="" type="checkbox"/>		
No peripheral edema	yes no	
<input checked="" type="checkbox"/>		
GASTROINTESTINAL		
Abdomen soft, with no masses	yes no	
<input checked="" type="checkbox"/>		
No hepatosplenomegaly	yes no	
<input checked="" type="checkbox"/>		
No hernias	yes no	
<input checked="" type="checkbox"/>		
Heme occult negative	yes no	
<input checked="" type="checkbox"/>		
MUSCULOSKELETAL		
Normal gait and station	yes no	
<input checked="" type="checkbox"/>		
No digital cyanosis or clubbing	yes no	
<input checked="" type="checkbox"/>		
SKIN		
No rashes, ulcers or lesions	yes no	
<input checked="" type="checkbox"/>		
Normal turgor and temperature	yes no	
<input checked="" type="checkbox"/>		
NEUROLOGIC		
CNs intact	yes no	
<input checked="" type="checkbox"/>		
No sensory deficits	yes no	
<input checked="" type="checkbox"/>		
DTRs intact and symmetrical	yes no	
<input checked="" type="checkbox"/>		
PSYCHIATRIC		
Appropriate affect	yes no	
<input checked="" type="checkbox"/>		
A&OX3	yes no	
<input checked="" type="checkbox"/>		
Intact judgment and insight		

w/legz & ankles
2+ edema
Distal feet non-tender
Some clubbing
BRUISING ON HEELS

Review of Systems			
Constitutional			
Weight loss	no yes	Musculoskeletal	no yes
<input checked="" type="checkbox"/>		Arthralgias	<input checked="" type="checkbox"/>
Fevers	no yes	Myalgias	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>		Muscle weakness	<input type="checkbox"/>
Chills	no yes	Joint swelling	<input type="checkbox"/>
<input type="checkbox"/>		NSAID use	<input type="checkbox"/>
Night sweats	no yes	Other:	
<input type="checkbox"/>			
Fatigue	no yes	Other:	
<input type="checkbox"/>			
Eyes			
Blurry vision	no yes	Rash	no yes
<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
Eye pain	no yes	Pruritis	no yes
<input type="checkbox"/>		<input type="checkbox"/>	
Discharge	no yes	Sores	no yes
<input type="checkbox"/>		<input type="checkbox"/>	
Dry eyes	no yes	Nail changes	no yes
<input type="checkbox"/>		<input type="checkbox"/>	
Decreased vision	no yes	Skin thickening	no yes
<input checked="" type="checkbox"/>		<input type="checkbox"/>	
Bas/Nose/Throat			
Sore throat	no yes	Neurological	no yes
<input checked="" type="checkbox"/>		Migraines	<input checked="" type="checkbox"/>
Tinnitus	no yes	Numbness	no yes
<input type="checkbox"/>		<input checked="" type="checkbox"/>	
Bloody nose	no yes	Ataxia	no yes
<input type="checkbox"/>		<input type="checkbox"/>	
Hearing loss	no yes	Tremors	no yes
<input type="checkbox"/>		<input type="checkbox"/>	
Sinusitis	no yes	Vertigo	no yes
<input checked="" type="checkbox"/>		<input type="checkbox"/>	
Respiratory			
Short of breath	no yes	Endocrine	no yes
<input checked="" type="checkbox"/>		Excess thirst	<input checked="" type="checkbox"/>
Cough	no yes	Polyuria	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>		Cold intolerance	<input type="checkbox"/>
Hemoptysis	no yes	Heat intolerance	no yes
<input checked="" type="checkbox"/>		<input type="checkbox"/>	
Wheezing	no yes	Goiter	no yes
<input checked="" type="checkbox"/>		<input type="checkbox"/>	
Pleurisy	no yes	Other:	
<input type="checkbox"/>			
Cardiovascular			
Chest pain	no yes	Psychiatric	no yes
<input checked="" type="checkbox"/>		Depression	<input checked="" type="checkbox"/>
PND	no yes	Anxiety	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>		Anti-depressants	<input type="checkbox"/>
Palpitations	no yes	Alcohol abuse	no yes
<input type="checkbox"/>		<input type="checkbox"/>	
Edema	no yes	Drug abuse	no yes
<input checked="" type="checkbox"/>		Insomnia	<input type="checkbox"/>
Orthopnea	no yes	Other:	
<input type="checkbox"/>			
Syncope	no yes	Other:	
<input type="checkbox"/>			
Gastrointestinal			
Nausea	no yes	Hem/Lymphatic	no yes
<input checked="" type="checkbox"/>		Easy bruising	<input checked="" type="checkbox"/>
Vomiting	no yes	Bleeding diathesis	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>		Blood clots	<input type="checkbox"/>
Diarrrhea	no yes	Swollen glands	no yes
<input type="checkbox"/>		<input type="checkbox"/>	
Hematemesis	no yes	Lymphedema	no yes
<input type="checkbox"/>		<input type="checkbox"/>	
Melena	no yes	Other:	
<input type="checkbox"/>			
Genitourinary			
Hematuria	no yes	Allergic/Immune	no yes
<input checked="" type="checkbox"/>		Allergic rhinitis	<input checked="" type="checkbox"/>
Dysuria	no yes	Hay fever	no yes
<input checked="" type="checkbox"/>		<input type="checkbox"/>	
Hesitancy	no yes	Asthma	no yes
<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
Incontinence	no yes	Positive PPD	no yes
<input type="checkbox"/>		<input checked="" type="checkbox"/>	
UTIs	no yes	Hives	no yes
<input type="checkbox"/>		<input type="checkbox"/>	
Other:			

4	3	1	2	1
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Assessment (Assign problem points)
COPD exacerbation (severe)
COPD exacerbation
HTN
DM

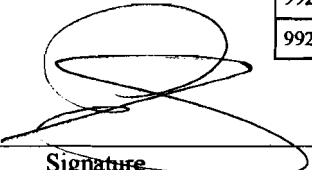
MDM	Prob Pts	Data Pts	Risk
SF <input type="checkbox"/>	≤1	1	Min
Low <input type="checkbox"/>	2	2	Low
Mod <input type="checkbox"/>	3	3	Mod
High <input checked="" type="checkbox"/>	≥4	4	High

Only 2 out of 3 MDM dimensions required

Plan

- troponin
- ACE nbs
- EKG
- steroids
- Remsh tele

99221
 99222
 99223



Minimal Risk <input type="checkbox"/>	Low Risk <input type="checkbox"/>	Moderate Risk <input type="checkbox"/>	High Risk <input checked="" type="checkbox"/>
•One self limited problem (e.g., cold, insect bite)	•Two self-limited problems •One stable chronic illness •Acute uncomplicated illness (e.g., cystitis/rhinitis) •OTC drugs	•Mild exacerbation of one chronic illness •Two stable chronic illnesses •Undiagnosed new problem •Acute illness with systemic symptoms (e.g., pyelonephritis, colitis) •Prescription drug management	•Severe exacerbation of chronic illness •Illness with threat to life or bodily function •Abrupt change in neurological status (e.g., TIA/weakness) •Parenteral controlled substances •Decision for DNR or to de-escalate care •Drugs requiring intensive monitoring for toxicity