

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

Patient: _____ Date: _____

New Office Visit

| 3 out of 3 Key Components Required | | | | |
|------------------------------------|------|------|------|------|
| E/M | Hx | Exam | MDM | Time |
| 99201 | PF | PF | SF | 10 |
| 99202 | EPF | EPF | SF | 20 |
| 99203 | Det | Det | Low | 30 |
| 99204 | Comp | Comp | Mod | 45 |
| 99205 | Comp | Comp | High | 60 |

Chief Complaint:

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

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

Pertinent Past Medical, Family and Social History

PMH | _____

FH | _____

SH | _____

Level of History Documented

Problem Focused: Brief HPI, no ROS/PFSH | EPF: Brief HPI, ROS, no PFSH

Detailed: Ext HPI, 2 - 9 ROS, 1/3 PFSH | Comp: Ext HPI, 10 ROS, 3/3 PFSH

Data Collected

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 |
| 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

| Psychiatry Physical Exam | |
|--|-----------------------|
| CONSTITUTIONAL | |
| Document any THREE vital signs | (One bullet) |
| Blood pressure | |
| Pulse | |
| Respirations | |
| Temperature | |
| Height | |
| Weight | |
| Describe general appearance | (One bullet) |
| Well-groomed | (Other) |
| Well-nourished | |
| Well-developed | |
| MUSCULOSKELETAL | yes no Other findings |
| Normal gait and station | |
| Normal muscle strength/tone | |
| PSYCHIATRIC | yes no Other findings |
| Normal speech rate & volume | |
| Normal thought content | |
| Associations intact | |
| Normal or psychotic thoughts (e.g., hallucinations, delusions, obsessions, SI) | |
| Judgment & insight intact | |
| Alert and oriented X 3 | |
| Recent and remote memory intact | |
| Normal attention span and concentration | |
| Normal language (naming objects, repeating phrases) | |
| Normal fund of knowledge | |
| Congruent mood and affect (no depression, anxiety, etc) | |

Levels of Physical Exam

PF = 1- 5 bullets

EPF = 6 bullets

Detailed = 9 bullets

Comp = ALL constitutional and psychiatric bullets plus ONE musculoskeletal bullet

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

New, further w/u is planned

New, no further w/u planned

Self-limited or minor (max 2)

Established, not controlled

Established, stable

Assessment (Assign problem points on the left.)

| 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 type="checkbox"/> | ≥ 4 | 4 | High |

Only 2 out of 3 MDM dimensions required

Plan

| | |
|-------|--------------------------|
| 99212 | <input type="checkbox"/> |
| 99213 | <input type="checkbox"/> |
| 99214 | <input type="checkbox"/> |
| 99215 | <input type="checkbox"/> |

Signature _____

| Minimal Risk <input type="checkbox"/> | Low Risk <input type="checkbox"/> | Moderate Risk <input type="checkbox"/> | High Risk <input type="checkbox"/> |
|--|---|---|---|
| <ul style="list-style-type: none"> One self limited problem (e.g., cold, insect bite) | <ul style="list-style-type: none"> Two self-limited problems One stable chronic illness Acute uncomplicated illness (e.g., cystitis/rhinitis) OTC drugs | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 |