

| 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 | | |
| Syncope | | | 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: _____

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:

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

Past Medical, Family and Social History

PMH | _____

FH | _____

SH | _____

Level of History Documented

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

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"/> |

| Physical Exam (Each check box = 1 bullet) | | | Abnormal Findings |
|---|-----|----|-------------------|
| CONSTITUTIONAL* | | | |
| Record three vital signs | yes | no | |
| Conversant/NAD | | | |
| NECK | yes | no | |
| Non-tender, no masses | | | |
| No thyromegaly or nodules | | | |
| RESPIRATORY | yes | no | |
| Normal respiratory effort | | | |
| Clear to auscultation | | | |
| CARDIOVASCULAR | yes | no | |
| RRR, no MRGs | | | |
| No peripheral edema | | | |
| GASTROINTESTINAL* | yes | no | |
| Abdomen soft, with no masses | | | |
| No hepatosplenomegaly | | | |
| No hernias | | | |
| Guaiac negative (if indicated) | | | |
| GENITOURINARY (female)* (Need 7 for comprehensive) | yes | no | |
| No breast masses or tenderness | | | |
| Normal rectal tone, no masses | | | |
| Normal external genitalia | | | |
| Normal urethral meatus | | | |
| No urethral masses/tenderness | | | |
| No bladder fullness or masses | | | |
| No vaginal lesions or discharge | | | |
| No cervical lesions or discharge | | | |
| Normal uterine size, contour | | | |
| No adnexal tenderness/masses | | | |
| Normal anus and perineum | | | |
| SKIN | yes | no | |
| No rashes, ulcers or lesions | | | |
| LYMPHADENOPATHY? | yes | no | |
| Neck <input type="checkbox"/> Axillae <input type="checkbox"/> Groin <input type="checkbox"/> | | | |
| NEURO/PSYCHIATRIC | yes | no | |
| Appropriate affect | | | |
| A&OX3 | | | |

- Problem Focused Exam: 1 - 5 bullets
- Expanded Problem Focused Exam : 6 - 11 bullets
- Detailed Exam: 12 bullets
- Comprehensive Exam: All bullets from starred systems plus one bullet from EVERY other system

Assessment (Assign problem points on the left.)

| 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

| 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

| | |
|-------|--------------------------|
| 99221 | <input type="checkbox"/> |
| 99222 | <input type="checkbox"/> |
| 99223 | <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 |