

NAME

DATE:

ENVIRONMENTAL AND SOCIAL:				
HOME/APT (FLOOR) STYLE:		LENGTH OF OCCUPANCY		
HEAT (CENTRAL FORCED AIR RADIATOR				
AIR CONDITIONING CENTRAL <input type="checkbox"/>		WINDOW UNITS <input type="checkbox"/>		HUMIDIFIER CENTRAL <input type="checkbox"/> SEPARATE UNITS <input type="checkbox"/>
BASEMENT (DAMP <input type="checkbox"/> MUSTY <input type="checkbox"/> SEEPAGE <input type="checkbox"/> FLOODING <input type="checkbox"/>)				
BEDROOM BOX SPRING <input type="checkbox"/> MATTRESS <input type="checkbox"/>		COVERS YES <input type="checkbox"/> NO <input type="checkbox"/>		
PILLOW FEATHER <input type="checkbox"/> NON FEATHER <input type="checkbox"/>		COMFORTER FEATHER <input type="checkbox"/> NON FEATHER <input type="checkbox"/>		
FLOORING: LIVING AREA		BEDROOM		BASEMENT
PETS DOG <input type="checkbox"/> CAT <input type="checkbox"/> BIRD <input type="checkbox"/> OTHER:		BEDROOM PETS		PREV. PET
SMOKERS		ROACHES		
DISEASE IMPACT ON FUNCTION				
MARITAL STATUS S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>		EDUCATION		
OCCUPATION				
SMOKING : CURRENT		PAST		SECONDARY
DRUG/ALCOHOL USE				
HOBBIES:				
FAMILY HISTORY				
PARENTS				
SIBLINGS				
OTHER				
REVIEW OF SYSTEMS (PROBLEM PERTINENT1, EXTENDED 2-9, COMPLETE 10)				
	SYSTEMS	DEFER	+	POSITIVE FINDINGS
<input type="checkbox"/>	EYES	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	ENT	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	CARDIOVASCULAR	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	RESPIRATORY	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	GASTROINTESTINAL	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	GENITOURINARY	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	MUSCULOSKELETAL	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	INTEGUMENTARY	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	NEUROLOGICAL	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	PSCHYIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	ENDOCRINE	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	HEMATOLOGIC/LYMPHATIC	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

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(PROBLEM FOCUSED 1-5, EXP PROBLEM FOCUSED 6, DETAILED 12, COMPREHENSIVE ALL)

CONSTITUTIONAL 3/6	PULSE:	TEMP:	BP: /	RESP:	HT	WT:	GENERAL:
				NORMAL			POSITIVE FINDINGS
HEAD AND FACE	SINUS TENDERNESS						
EYES	CONJUCTIVAE/LIDS						
ENT	OTOSCOPIE						
	OROPHARYNX						
	TEETH AND GUMS						
	NASAL MUCOSA,SEPTUM, TURBINATES						
NECK	NECK EXAMINATION						
	THYROID						
RESPIRATORY	EFFORT						
	AUSCULTATION						
CARDIOVASCULAR	AUSCULTATION OF HEART						
	PERIPHERAL VASCULAR SYSTEM						
GASTROINTESTINAL	ABDOMINAL EXAM						
	LIVER AND SPLEEN						
GENITOURINARY							
LYMPHATIC	NECK						
(ALL COUNT AS 1 ELEMENT)	AXILLAE						
	GROIN						
	OTHER						
SKIN	INSPECTION						
	PALPATION						
MUSCULOSKELETAL							
EXTREMITIES	DIGITS AND NAILS						
NEUROLOGICAL PSYCHIATRIC	MENTAL STATUS ORIENTATION X3						
	MOOD AND AFFECT						

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TESTS ORDERED OR REVIEWED		
	ORDERED	REVIEWED
CBC		
SKIN TESTS		
PFT		
RADIOLOGY		

REQUEST RECORDS

REVIEW RECORDS:

DIAGNOSIS OR IMPRESSION	CODE

PLAN:

FOLLOW UP: DAYS WEEKS MONTHS PRN

SIGNATURE: _____ TIME OUT AM PM

TOTAL TIME: _____

DOCUMENTATION

HISTORY OF PRESENT ILLNESS	REVIEW OF SYSTEMS	PAST, FAMILY AND/OR SOCIAL HISTORY	PHYSICAL EXAMINATION	TYPE OF HISTORY
BRIEF 1-3	N/A	N/A	1-5 ELEMENTS	<i>PROBLEM FOCUSED</i>
BRIEF 1-3	PROBLEM PERTINENT 1	N/A	AT LEAST 6 ELEMENTS	<i>EXPANDED PROBLEM FOCUSED</i>
EXTENDED >4 ≥3MULT CHR	EXTENDED 2-9	PERTINENT 1	AT LEAST 12 ELEMENTS	<i>DETAILED</i>
EXTENDED >4 ≥3MULT CHR	COMPLETE ≥10	COMPLETE 3	ALL ELEMENTS IN SHADED AND 1 UNSHADED	<i>COMPREHENSIVE</i>