

Encounter Forms for Better Preventive Visits



These two tools can help improve your care and documentation.

Peter A. Cardinal, MD, MHA



Covered in FPM Quiz



Tool inside

The foundation of disease prevention is identifying the patients' conditions and the effective interventions available. This takes a long time using traditional history-taking, which leaves less visit time for other issues. Many traditional comprehensive history forms include issues that are not associated with evidenced-based interventions. And even when a physician makes a special effort to keep up with proven screening test recommendations, it is difficult to remember all the recommendations that apply to a specific patient.

To address these issues, I developed comprehensive tools that include a patient-completed history, exam documentation template and evidence-based screening test recommendations for all age groups. The tools, which appear on page 36 and can be downloaded online at www.aafp.org/fpm/20030700/35enco.html, can be modified to conform to specific practice parameters or changes in disease-prevention recommendations.

How they work

Patients complete the history section, which is structured to allow what for most reasonably healthy patients will be a brief review by the physician. Standard medical and family history questions are included as well as questions about common issues that we often forget to ask about, such as sexual and urinary function, depression, sleep problems and addictions. All of the questions are written at an upper elementary level, but physicians should direct staff members to be sensitive to those patients who may not be able to read or completely understand the questions.

Physicians and other providers complete the last page of the forms. Practices can decide whether to attach this last page to the rest of the encounter form before or after the patient fills out the history section. A small amount of space at the top is designated for documentation of additional history. If the additional history relates specifically to

one of the questions on the history portion of the forms, it may be easier to document it in the margin near the appropriate question. The physical exam items can be completed quickly by circling "normal" or "abnormal" and noting any specific abnormalities. Below the exam items, space is also provided for diagnoses and any associated plans that are not preventive. Finally, the "plan" section lists diagnostic and therapeutic preventive service recommendations from the U.S. Preventive Services Task Force, grouped by age where appropriate.

The concern has been raised that this form's extensive screening medical history will lead to a lengthy office visit. However, I've not found that to be the case. If time permits, a minor issue can be dealt with as part of the preventive visit. Otherwise, the patient can return for a follow-up visit, or visits, to more extensively address any additional problems. Because the specific items on the encounter form are scientifically well supported, any additional visits generated by the form will be appropriate.

The benefits

After using these preventive-visit encounter forms in my practice, I found that they simultaneously save time and improve patient flow, documentation and quality of care. Having patients complete their own, extensive medical history gives them something productive to do during a portion of their waiting time, promotes more honest answers and provides an effective illness identification tool. Visits are shorter or, in some cases, allow enough time for educating patients on unhealthy behaviors and chronic diseases that are often not adequately addressed. The encounter forms also make documentation more complete and improve the quality of the preventive care by reminding the physician to order the most up-to-date, evidence-based interventions. ►

Send comments to fpmedit@aaafp.org.

Dr. Cardinal is the vice president of medical affairs at Gettysburg Hospital, a 100-bed community hospital in Gettysburg, Pa. Previously, he oversaw a practice network with more than 300,000 visits per year. Conflicts of interest: none reported.

WELL-WOMAN EXAM



To help your doctor during today's health exam, please complete items 1 through 11.

1. Age: _____
First day of last menstrual period (or first year of menstruation, if through menopause): _____
2. Number of times pregnant: _____
Number of completed pregnancies: _____
Date of last pregnancy: _____
If you are under age 55, what method of birth control do you use? _____
If pills, what kind? _____
How many years have you used the pills? _____
Are you planning a pregnancy YES NO in the next 6-12 months?
3. If you are through menopause or over age 50, do you take any of the following pills?

Calcium	<input type="radio"/> YES	<input type="radio"/> NO
Estrogen (Premarin)	<input type="radio"/> YES	<input type="radio"/> NO
Progesterone (Provera)	<input type="radio"/> YES	<input type="radio"/> NO
4. Have you had any of the following problems:
 - a. Abnormal Pap smears YES NO
If yes, date: _____ problem: _____
For abnormality, did you have any of the following done:

Colposcopy	<input type="radio"/> YES	<input type="radio"/> NO
Biopsies	<input type="radio"/> YES	<input type="radio"/> NO
Surgery	<input type="radio"/> YES	<input type="radio"/> NO
 - b. High blood pressure, heart disease or high cholesterol YES NO
 - c. Migraine headaches, blood clot in legs or cancer YES NO
 - d. Abdominal or pelvic surgery or special tests YES NO
If yes, what: _____ when: _____
5. Do you have any of the following:
 - a. Problems with present method of birth control YES NO
 - b. Bleeding between periods or since periods stopped YES NO
 - c. Pain with intercourse or periods YES NO
 - d. Any problem with interest in or enjoying intercourse YES NO
 - e. A new or enlarging lump in breast YES NO
 - f. Change in size/firmness of stools YES NO
 - g. Change in size/color of a mole YES NO
 - h. Severe headaches YES NO
 - i. Pain in the leg, chest, abdomen or joints YES NO
 - j. Trouble falling or staying asleep YES NO
 - k. Often feeling down, depressed or hopeless during the past month YES NO
 - l. Often having little interest or pleasure in doing things during the past month YES NO
 - m. Conflict in your family or relationships, sometimes handled by pushing, hitting or cruelty YES NO
6. Do you have a parent, brother or sister with a history of the following:
 - a. Cancer of the breast, intestine or female organs YES NO
 - b. Heart pain or heart attacks before the age of 55 YES NOIf yes to a or b:
Relation: _____ Type: _____
Relation: _____ Type: _____
7. Osteoporosis (thin-bone) screening:
 - a. Is there a history of any relatives with the following: stooping over or losing height as they got older, "thin bones," hip fractures YES NO
If yes, relation: _____
 - b. Have you had any of the following:

Height loss	<input type="radio"/> YES	<input type="radio"/> NO
Broken hip or wrist	<input type="radio"/> YES	<input type="radio"/> NO
Bone-density test	<input type="radio"/> YES	<input type="radio"/> NO
 - c. Do you take any of the following:

Steroids (prednisone)	<input type="radio"/> YES	<input type="radio"/> NO
Medication for thyroid, seizures or thin bones	<input type="radio"/> YES	<input type="radio"/> NO
8. Have you ever used tobacco? YES NO
If yes:
Average number of packs/day: _____
Number of years smoked: _____
Year quit: _____
When are you planning to quit?
 now next 6 months sometime never

WELL-MALE EXAM

To help your doctor during today's health exam, please complete items 1 through 8.

1. Age: _____
2. Have you had any of the following problems:
 - a. High blood pressure YES NO
 - b. Heart disease YES NO
 - c. Cancer YES NO
 - d. High cholesterol YES NO
3. Do you have any of the following problems:
 - a. Bothersome joint pains YES NO
 - b. Sexual problems (getting and keeping erections, completing intercourse, etc.) YES NO
 - c. Change in size/firmness of stools YES NO
 - d. Change in size/color of a mole YES NO
 - e. Sleeping poorly or having any trouble falling or staying asleep during the past month YES NO
 - f. Often feeling down, depressed or hopeless during the past month YES NO
 - g. Often having little interest or pleasure in doing things during the past month YES NO
 - h. Difficulty with urine stream strength or flow rate YES NO
 - i. Getting up frequently at night to urinate YES NO
 - j. Chest pain, shortness of breath, stomach problems or heartburn YES NO
 - k. Problems with falling or doing routine tasks at home YES NO
 - l. Periods of weakness, numbness or inability to talk YES NO
4. Do you have a parent, brother or sister with a history of the following:
 - a. Cancer of the prostate or intestine YES NO
 - b. Heart pain or heart attacks before the age of 55 YES NO
 If yes to a or b:
 Relation: _____ Type: _____
 Relation: _____ Type: _____
5. Have you ever used tobacco? YES NO
 If yes:
 Average number of packs/day: _____
 Number of years smoked: _____
 Year quit: _____
 When are you planning to quit?
 now next 6 months sometime never
6. Do you drink alcohol? YES NO
 If yes:
 - a. Have you ever felt you should cut down on your drinking? YES NO
 - b. Have people ever annoyed you by nagging you about your drinking? YES NO
 - c. Have you ever felt guilty about your drinking? YES NO
 - d. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? YES NO
7. Prevention:
 - a. Which of the following are included in your diet:

Grains and starches	<input type="radio"/> a lot	<input type="radio"/> some	<input type="radio"/> few
Vegetables	<input type="radio"/> a lot	<input type="radio"/> some	<input type="radio"/> few
Dairy foods	<input type="radio"/> a lot	<input type="radio"/> some	<input type="radio"/> few
Meats	<input type="radio"/> a lot	<input type="radio"/> some	<input type="radio"/> few
Sweets	<input type="radio"/> a lot	<input type="radio"/> some	<input type="radio"/> few
 - b. Exercise:

Activity _____

Days per week _____

Time/duration _____ minutes

Exertion: stroll mild heavy
 - c. Do you always wear seat belts? YES NO
 - d. If over 30 years old, have you had your cholesterol level checked in the past five years? N/A YES NO
 - e. Have you had a tetanus shot in the past 10 years? YES NO
 - f. Does your house have a working smoke detector? YES NO
 - g. Do you have firearms at home? YES NO
 - h. How many sexual partners have you had in the last 12 months? ____ In your lifetime? ____
 - i. When is the last time you had a dental check-up? _____
8. Please describe any concerns you have:

WELL-MALE EXAM

Date: _____

Height	Weight	Overweight	BP
		<input type="radio"/> YES <input type="radio"/> NO	

If necessary				ALLERGIES
Temp	Pulse	Resp	O ₂ Sat	

Other complaints/hpi:

Physical exam: As indicated by past medical history (none of the following are specifically recommended by USPSTF):

- Oral exam (if smoker): Normal Abnormal:
- HEENT: Normal Abnormal:
- Heart: Normal Abnormal:
- Lungs: Normal Abnormal:
- Genitourinary: Normal Abnormal:
- Abdomen: Normal Abnormal:
- Prostate: Normal Abnormal:
- Rectum: Normal Abnormal:
- Skin: Normal Abnormal:
- Extremities: Normal Abnormal:

Diagnoses (#s correspond to problem list):

Plan:

All patients:

- Handout given and reinforced healthy diet, lifestyle, exercise and safety
- Immunizations: flu, Td (q 10 yrs)
- Recommended dental exam
- Other:

Over 40 y/o:

- Cholesterol
- Coated ASA: 325 mg/d 81 mg/d

Over 50 y/o:

- Coated ASA: 325 mg/d 81 mg/d
- Immunizations: pneumococcal (>65 y/o)
- Colon cancer screen: colonoscopy ACBE flex sig stool guaiac x 3
- Calcium R_x: 600 mg/d 1200 mg/d
- PSA (controversial)

Follow-Up:

- Routine visit in _____ for _____
- Physical exam in _____

Name: _____

Physician signature: _____

DOB: ____/____/____

Physician name: _____

Chart #: _____

