ACUTE KNEE INJURY ENCOUNTER FORM

Patient’s name: ____________________________ Age: _______ Medical record #: __________

History of present illness
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Patient experienced the following:
☐ Pop or tear with injury
☐ Locking of knee
☐ Knee giving way

Physical Examination

General examination: Left knee: Right knee: Comments:

Effusion
☐ Yes ☐ No ☐ NE ☐ Yes ☐ No ☐ NE

Erythema
☐ Yes ☐ No ☐ NE ☐ Yes ☐ No ☐ NE

Warmth
☐ Yes ☐ No ☐ NE ☐ Yes ☐ No ☐ NE

Range of motion
☐ NI ☐ Abnl ☐ NE ☐ NI ☐ Abnl ☐ NE

Strength
☐ NI ☐ Abnl ☐ NE ☐ NI ☐ Abnl ☐ NE

Neurovascular
☐ NI ☐ Abnl ☐ NE ☐ NI ☐ Abnl ☐ NE

Maneuvers for ACL tear (PV+, PV-):

Lachman (58%, 2%)
☐ NI ☐ Abnl ☐ NE ☐ NI ☐ Abnl ☐ NE

Pivot (69%, 4%)
☐ NI ☐ Abnl ☐ NE ☐ NI ☐ Abnl ☐ NE

Anterior drawer (29%, 6%)
☐ NI ☐ Abnl ☐ NE ☐ NI ☐ Abnl ☐ NE

Maneuver for meniscus injury (PV+, PV-):

McMurray (66%, 5%)
☐ NI ☐ Abnl ☐ NE ☐ NI ☐ Abnl ☐ NE

NE = not examined; ACL = anterior cruciate ligament; NI = normal; Abnl = abnormal.

Note: See reverse side for diagrams of maneuvers. Predictive values (PV) for each maneuver are based on a pretest probability of 10 percent. If your clinical suspicion is higher or lower than this, then the PV should be correspondingly higher or lower.

Other comments: ____________________________________________________________

Radiographic Decision-making

Radiograph indicated if any of the following are true:
☐ Age less than 12 years
☐ Age 55 years or older
☐ Tenderness at head of fibula
☐ Isolated tenderness of patella (i.e., no bone tenderness of knee other than patella)
☐ Inability to flex knee to 90°
☐ Inability to take four weight-bearing steps (regardless of limping) at the time of injury and during examination.
☐ Radiograph not indicated.
☐ Radiograph indicated; findings: __________________________________________________

Assessment/Plan

Working diagnosis:
☐ Contusion ☐ Strain ☐ ACL tear ☐ Medial cruciate ligament tear
☐ Medial meniscus injury ☐ Lateral meniscus injury ☐ Other: ___________________________

☐ Exam limited; reevaluate in _______ days

Orders:
☐ Magnetic resonance imaging (MRI)
☐ Knee immobilizer
☐ Cast
☐ Ice
☐ No weight bearing for ________ days
☐ Refer to: ______________
☐ Recheck in ________ days

Pain medication:
☐ Acetaminophen (Tylenol): ________ mg orally, _______ time(s) per day for ______ days; number of refills: ______
☐ Nonsteroidal anti-inflammatory drug: ________ , ________ mg orally prn for ______ days; number of refills: ______
☐ Oral narcotic: ________ , ________ mg orally prn for ______ days; number of refills: ______

☐ Other: __________________________

Physician's Signature: ____________________________ Date: ____________________________
Common Maneuvers of the Knee for Assessing Possible Ligamentous and Mensical Damage

**Anterior drawer test (Top left).** Place patient supine, flex the hip to 45 degrees and the knee to 90 degrees. Sit on the dorsum of the foot, wrap your hands around the hamstrings (ensuring that these muscles are relaxed), then pull and push the proximal part of the leg, testing the movement of the tibia on the femur. Do these maneuvers in three positions of tibial rotation: neutral, 30 degrees externally rotated, and 30 degrees internally rotated. A normal test result is no more than 6 to 8 mm of laxity.

**Lachman test (Top right).** Place patient supine on examining table, leg at the examiner’s side, slightly externally rotated and flexed (20 to 30 degrees). Stabilize the femur with one hand and apply pressure to the back of the knee with the other hand with the thumb of the hand exerting pressure placed on the joint line. A positive test result is movement of the knee with a soft or mushy end point.

**Pivot test (Bottom left).** Fully extend the knee, rotate the foot internally. Apply a valgus stress while progressively flexing the knee, watching and feeling for translation of the tibia on the femur.

**McMurray test (Bottom right).** Flex the hip and knee maximally. Apply a valgus (abduction) force to the knee while externally rotating the foot and passively extending the knee. An audible or palpable snap during extension suggests a tear of the medial meniscus. For the lateral meniscus, apply a varus (adduction) stress during internal rotation of the foot and passive extension of the knee.

ACUTE OTITIS MEDIA (AOM) ENCOUNTER FORM

Patient's name: ______________________  Age/Date of birth: _______ / ________  Medical record #: __________________________

History of present illness


Physical examination

Blood pressure: ____________________  Heart rate: __________  Temperature: __________

General:  ☐ Alert, appropriate  ☐ Other: ____________________

Eyes:  ☐ Conjunctiva not injected  ☐ Other: ____________________

Nose:  ☐ Normal mucosa, no discharge  ☐ Other: ____________________

Pharynx:  ☐ Normal pharynx and tonsils  ☐ Other: ____________________

Lungs:  ☐ Clear to auscultation bilaterally  ☐ Other: ____________________

Skin:  ☐ No rash or lesions  ☐ Other: ____________________

Certain diagnosis of acute otitis media requires at least one item in each of groups A, B and C:

A. Acute onset
☐ Recent, usually abrupt onset of signs and symptoms of middle-ear inflammation and effusion

B. Middle-ear effusion
☐ Left  ☐ Right  Bulging of the tympanic membrane
☐ Left  ☐ Right  Limited or absent mobility of the tympanic membrane
☐ Left  ☐ Right  Air-fluid level behind the tympanic membrane
☐ Left  ☐ Right  Otorrhea

C. Middle-ear inflammation
☐ Left  ☐ Right  Distinct erythema of the tympanic membrane
☐ Left  ☐ Right  Distinct otalgia (discomfort clearly referable to the ear[s] that interferes with or precludes normal activity or sleep)

Assessment/plan

Diagnosis:
☐ Acute otitis media:  ☐ Left  ☐ Right  Diagnostic certainty (based on A, B and C, above):  ☐ Certain  ☐ Uncertain

Severity:  ☐ Severe (temperature of 39°C [102.2°F] or moderate-to-severe otalgia)  ☐ Not severe

☐ Otitis externa  ☐ Cerumen impaction  ☐ Upper respiratory infection  ☐ Pharyngitis  ☐ Other: ____________________

Management:
☐ Antibiotic therapy not indicated (see Decision Support, over). Observe for 48 to 72 hours. If the patient is not improving, reevaluate and consider antibiotic therapy.

☐ Antibiotic therapy indicated (see Decision Support, over). Select from the options below:

Initial treatment of nonsevere infection:
☐ Amoxicillin, 40 to 45 mg per kg orally twice daily for 10 days (6 to 7 days if the patient is at least six years of age and has nonsevere illness)

If the patient is allergic to the above, consider one of the following agents:
☐ Cefdinir, 7 mg per kg orally twice daily for 5 to 10 days
☐ Cefuroxime, 15 mg per kg orally twice daily for 10 days
☐ Cefpodoxime, 10 mg per kg orally once daily for 5 days
☐ Azithromycin, 10 mg per kg orally once daily for 1 day, followed by 5 mg per kg once daily for 4 days
☐ Clarithromycin, 7.5 mg per kg orally twice daily for 10 days

Initial treatment of severe infection:
☐ Amoxicillin-clavulanate, 45 mg per kg/3.2 mg per kg orally twice daily for 10 days

If the patient is unable to take antibiotics orally, consider this treatment:
☐ Ceftriaxone, 50 mg per kg per day intramuscularly for 3 days

Follow-up treatment for severe infection (initial antibiotic treatment failed):
☐ Ceftriaxone, 50 mg per kg per day intramuscularly for 3 days

If the patient is allergic to penicillin, consider this treatment:
☐ Typanocentesis plus clindamycin, 10 to 13 mg per kg orally every 8 hours for 10 days

Other follow-up treatment (see additional options listed in Antibiotic Selection table, over):
☐ ____________________

Pain control:
☐ Acetaminophen  ☐ Ibuprofen  ☐ Topical benzocaine drops  ☐ Other: ____________________

Follow-up:
☐ 48 to 72 hours  ☐ _____ days  ☐ p.r.n.
Decision support

Age: 2 months to 6 months
Antibiotics always recommended for suspected or certain AOM (see table below).

Age: 6 months to 2 years
Certain diagnosis of AOM: antibiotics recommended (see table below).
Uncertain diagnosis of AOM and severe illness (temperature of 39°C [102.2°F] or moderate-to-severe otalgia): antibiotics recommended (see table below).
Uncertain diagnosis of AOM and nonsevere illness: option of observation without antibiotics for 48 to 72 hours if follow-up is ensured.

Age: over 2 years
Certain diagnosis of AOM and severe illness (temperature of 39°C [102.2°F] or moderate-to-severe otalgia): antibiotics recommended (see table below).
Certain diagnosis of AOM and nonsevere illness: option of observation without antibiotics for 48 to 72 hours if follow-up is ensured.
Uncertain diagnosis of AOM and nonsevere illness: option of observation without antibiotics for 48 to 72 hours if follow-up is ensured.

antibiotic selection

<table>
<thead>
<tr>
<th>Severity</th>
<th>Initial management with antibacterial agents</th>
<th>Treatment failure at 48 to 72 hours after initial management with observation</th>
<th>Treatment failure at 48 to 72 hours after initial management with antibacterial agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonsevere</td>
<td>Amoxicillin</td>
<td>Type-I penicillin allergy: azithromycin, clarithromycin</td>
<td>Amoxicillin</td>
</tr>
<tr>
<td></td>
<td>Non-type-I allergy: cefdinir, cefuroxime, cefpodoxime</td>
<td>Type-I penicillin allergy: azithromycin, clarithromycin</td>
<td>Amoxicillin-clavulanate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-type-I allergy: cefdinir, cefuroxime, cefpodoxime</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>Amoxicillin-clavulanate  for 3 days</td>
<td>Amoxicillin-clavulanate for 3 days</td>
<td>Ceftriaxone for 3 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Recommended dosages
Amoxicillin, 40 to 45 mg per kg orally twice daily for 10 days
(6 to 7 days if the patient is at least six years of age and has nonsevere illness)
Amoxicillin-clavulanate, 45 mg per kg/3.2 mg per kg orally twice daily for 10 days
(6 to 7 days if the patient is at least six years of age and has nonsevere illness)
Ceftriaxone, 50 mg per kg intramuscularly for 1 day
Ceftriaxone, 50 mg per kg intramuscularly for 3 days (preferred)
Clindamycin, 10 to 13 mg per kg orally every 8 hours for 10 days
Cefdinir, 7 mg per kg orally twice daily for 5 to 10 days
Cefuroxime, 15 mg per kg orally twice daily for 10 days
Cefpodoxime, 10 mg per kg orally once daily for 5 days
Azithromycin, 10 mg per kg orally once daily for 1 day, followed by 5 mg per kg once daily for 4 days
Clarithromycin, 7.5 mg per kg orally twice daily for 10 days

Note: Dosages and durations of treatment are recommendations from the guideline on the diagnosis and management of acute otitis media released by the American Academy of Pediatrics and American Academy of Family Physicians. Pediatric doses based on weight should not exceed usual adult doses.
# Asthma Visit Documentation Form

**Name:** ___________________________________________________________________________   **Date:** __________________________________

**History number:** _________________________   **Peak flow personal best:** ___________________________________________________________

## Classification (circle appropriate category)

<table>
<thead>
<tr>
<th>Quick-acting medication</th>
<th>1: Mild intermittent</th>
<th>2: Mild persistent</th>
<th>3: Moderate persistent</th>
<th>4: Severe persistent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Night-time waking</td>
<td>≤ 2 times/week</td>
<td>3 to 6 times/week</td>
<td>Daily</td>
<td>All the time</td>
</tr>
<tr>
<td>Symptoms interference</td>
<td>None unless with attack</td>
<td>Only with lots of activity</td>
<td>Only with moderate activity</td>
<td>With any activity</td>
</tr>
<tr>
<td>FEV₁, PEF (% pred.)</td>
<td>≥ 80 percent</td>
<td>≥ 80 percent</td>
<td>&gt; 60 percent, &lt; 80 percent</td>
<td>≤ 60 percent</td>
</tr>
</tbody>
</table>

## Type of Visit

- Acute
- Follow-up
- Educational

## Social Issues

<table>
<thead>
<tr>
<th>BP: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse: ________________________</td>
</tr>
<tr>
<td>O₂ Sat: ______________________</td>
</tr>
<tr>
<td>RR: __________________________</td>
</tr>
</tbody>
</table>

## Days with Symptoms (#/wk):

<table>
<thead>
<tr>
<th>Days with symptoms (#/wk):</th>
<th>≤ 2 times/month</th>
<th>3 to 4 times/month</th>
<th>≥ 5 times/month</th>
<th>Frequent</th>
</tr>
</thead>
</table>

## Current Severity Score

<table>
<thead>
<tr>
<th>Current severity score:</th>
<th>1 2 3 4</th>
</tr>
</thead>
</table>

| Hospitalizations since last visit? | Y N Dates: __________________________ |

## Trigger avoidance/coping:

| Trigger avoidance/coping: | ________________ |

## Teacher Review / Update

<table>
<thead>
<tr>
<th>Review / Update</th>
<th>Review / Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action plan/education:</td>
<td>Trigger avoidance/coping:</td>
</tr>
<tr>
<td>Smoke/environment:</td>
<td>Controller meds:</td>
</tr>
<tr>
<td>Peak flow:</td>
<td>What asthma is:</td>
</tr>
<tr>
<td>Use of MDI/spacer/neb:</td>
<td>Exercise:</td>
</tr>
<tr>
<td>Other:</td>
<td>School/work issues:</td>
</tr>
</tbody>
</table>

## Planned follow-up:

| Planned follow-up: | ________________ |

| MD/PA/NP: | ________________ |

ROUTINE DIABETES ENCOUNTER

Name: __________________________________________ Date: ____________________

What is your goal for this visit? _____________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

What is the most difficult issue for you in managing your diabetes? ________________________
_________________________________________________________________________________
_________________________________________________________________________________

Next step to health successfully accomplished: □ Y □ N

Comments: ______________________________________________________________________

S: Feeling well: □ Y □ N

Comments: ______________________________________________________________________

Home SBG results reviewed: □ Y □ N Action if FBS > 140; 1-2 hr PP > 200

Physical activity: (#) _____ times/week

Diet adherence: □ Y □ N

Tobacco use: □ Y □ N

ASA use (≥ age 40): □ Y □ N

ACE inhibitor prescribed if age ≥ 55 or risk factor for CAD: □ Y □ N

Previous phone call dated: (m/d/y) ____________. Discussed: ______________________

ROS:

Vision problems: □ Y □ N Numbness: □ Y □ N Hypoglycemia: □ Y □ N

Chest pain: □ Y □ N Nausea; vomiting; diarrhea: □ Y □ N

Medications:

Med list reviewed and accurate □ Y or list: __________________________________________
________________________________________________________________________________


Cardiovascular exam: □ Normal □ Abnormal

If high risk: Visual foot exam: □ Poor circulation □ Problematic toenails □ Foot deformity

□ Ulcer □ Pre-ulcer callous/pressure point □ Tinea pedis

Lab reviewed: HbA1c: _______ Lipids: _______ Other: _______

Current (within past year): Retinal eye exam: _____ Urine for protein: _____ BUN/ Creatinine: _____ Neurofilament exam: ______

A: Diabetes Mellitus Type □ I □ II Control: □ good □ poor

□ 401.1 Hypertension: BP at goal □ Y □ N

□ 272.0 Hypercholesterolemia: Cholesterol at goal □ Y □ N

□ 275.00 Obesity

□ Other

continued ➤
ROUTINE DIABETES ENCOUNTER continued

P: Patient's next step to health: __________________________________________

____________________________________________________________________

____________________________________________________________________

☐ Medication changes: ________________________________________________

____________________________________________________________________

☐ Next visit: ________________  ☐ Routine  ☐ Recal  ☐ Follow-up problem

☐ Revisit promptly should new symptoms develop

☐ Schedule dilated eye exam

Lab: When __________________

☐ HbA1c  ☐ Fasting lipid panel  ☐ SGOT  ☐ BUN/ Creatinine  ☐ Urine for Albumin/ Creatinine

☐ Phone call follow-up: Scheduled for (m/d/y) __________________________ by: (name) __________________________

Education:

Discussed: __________________________________________________________

____________________________________________________________________

____________________________________________________________________

Handouts given: ______________________________________________________

____________________________________________________________________

Referral to: __________________________________________________________

Comments

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Physician signature: ___________________________  Date: ________________

ICD-9 Diagnostic Codes:

250.00 type 2 DM w/o complication, controlled
250.01 type 1 DM w/o complication, controlled
250.02 type 2 DM, uncontrolled
250.03 type 1 DM, uncontrolled
250.40 DM with renal manifestations
250.60 DM with neurological manifestations
250.70 DM with peripheral circulatory manifestations (such as gangrene, not atherosclerosis)
250.80 Diabetic hypoglycemia
TYPE 2 DIABETES PROGRESS NOTE FOR GROUP VISITS

Date: ____________________________
Patient Name: ____________________________  Patient ID #: ____________________________

Subjective:
Any history of hypoglycemia? ____________________________
Current activity level
☐ No activity  ☐ Moderate (2-3 times per week)  ☐ Moderate (4-6 times per week)
☐ Vigorous (4 or fewer times per week)  ☐ Vigorous (5 or more times per week)
Fat intake
☐ High  ☐ Medium  ☐ Low  ☐ Ultra low
Most common fat intake ____________________________
Produce serving intake
☐ Less than 2 daily  ☐ 3 to 4 daily  ☐ 5 or more daily

Pertinent past medical history: (See patient chart for details)

Meds: (See med list for details)

Tobacco use:  ☐ Current  ☐ Ex  ☐ Never

Objective: (labs with month/year)
   Weight _____  BP _____ / ______  Last monofilament foot exam (date _____ / ______): ______
   Recent lipid profile (date _____ / ______): TC/HDL (date _____ / ______): _____ / _____  LDL _____  TG _____
   FBS (date _____ / ______): _____ or HbA1c (date ______ / ______): ______
   Creatinine (date ______ / ______): ______  Urine microalbumin (date _____ / ______): ______
   Last retinal screening: ________

Assessment:
Type 2 diabetes (☐ at target / ☐ not at target); (☐ with / ☐ without complications)

Plan:
1. Reviewed management of HbA1c.
2. (New Rx: ____________________________)
3. (Labs due: ____________________________)
4. Recommended ASA daily.
5. Encouraged activity.
7. Reviewed med options: risks, benefits and side effects (including ACE inhibitors).
8. Discussed targets and management of lipids, HTN and proteinuria.
9. Spent more than 50 percent of this 105-minute visit in counseling re: therapy options and management of diabetes.

Signed: ____________________________
PROGRESS NOTE

Name: __________________________  Date: __________
Nurse’s Note: ________________________________________________________________

CC:

HPI:

Location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms.

ROS  WNL  See note
Const  ☐  ☐  ☐
Eyes  ☐  ☐  ☐
ENT/mouth  ☐  ☐  ☐
CV  ☐  ☐  ☐
Resp  ☐  ☐  ☐
GI  ☐  ☐  ☐
GU  ☐  ☐  ☐
Musc  ☐  ☐  ☐
Skin/breasts  ☐  ☐  ☐
Neuro  ☐  ☐  ☐
Psych  ☐  ☐  ☐
Endo  ☐  ☐  ☐
Hem/lymph  ☐  ☐  ☐
Allerg/immun  ☐  ☐  ☐

No noteworthy changes since last visit. See note dated: __________ __________

PFSH  No chng  See note
Past  ☐  ☐
Family  ☐  ☐
Social  ☐  ☐

No noteworthy changes since last visit. See note dated: __________ __________

Exam  WNL  See note
Const  ☐  ☐  ☐
Eyes  ☐  ☐  ☐
ENT/mouth  ☐  ☐  ☐
Neck  ☐  ☐  ☐
Resp  ☐  ☐  ☐
CV  ☐  ☐  ☐
Chest (breasts)  ☐  ☐  ☐
GI (abdomen)  ☐  ☐  ☐
Lymph  ☐  ☐  ☐
GU  ☐  ☐  ☐
Musc  ☐  ☐  ☐
Skin  ☐  ☐  ☐
Neuro  ☐  ☐  ☐
Psych  ☐  ☐  ☐
No ✔: no review/exam

Physician’s Signature: __________________________  Couns/coord time: _____ min.

Couns/coord > 50% ☐

Total time: _________ min.

## HOUSE CALL - MEDICARE

### Need for House Call:
- [ ] Pt home-bound
- [ ] O/V requires ambulance transport
- [ ] O/V requires excessive effort/pain

### CC

### HPI

### Physical Exam
- BP  
  - P
  - R
  - T
- HEENT
- Lungs
- Cor
- Abd
- Ext
- Skin

### Home Environment
- Smells:  
  - [ ] urine
  - [ ] roting
  - [ ] musty
  - [ ] OK
- Temp:  
  - [ ] x/s cold
  - [ ] x/s hot
  - [ ] OK
- Clean:  
  - [ ] clean
  - [ ] messy
  - [ ] dirty
  - [ ] OK
- Rugs:  
  - [ ] exposed rug edges
- Furniture:  
  - [ ] sturdy
  - [ ] flimsy
  - [ ] cluttered
- Toilet:  
  - [ ] accessible
  - [ ] inaccessible
  - [ ] toilet rails
  - [ ] shower rails
- Phone:  
  - [ ] accessible
  - [ ] inaccessible
- Food:  
  - [ ] healthy balance
  - [ ] x/s canned
  - [ ] x/s junk food
  - [ ] x/s salt/sugar
- Food quantity:  
  - [ ] adequate
  - [ ] scant
  - [ ] x/s
- Lighting:  
  - [ ] bright
  - [ ] mod
  - [ ] dim

### Patient Activity
- Walks in home:  
  - [ ] no assist
  - [ ] assist
  - [ ] no
- Uses prescribed walker/cane:  
  - [ ] y
  - [ ] n
- Pt falling:  
  - [ ] y
  - [ ] n
  - freq:  
- Pt dresses self:  
  - [ ] y
  - [ ] n
- Pt bathes self:  
  - [ ] y
  - [ ] n
- Pt cooks for self:  
  - [ ] y
  - [ ] n

### Support
- Family visits:  
  - [ ] qwk
- Friend visits:  
  - [ ] qwk
- Nurse visits:  
  - [ ] qwk
- HH Aid visits:  
  - [ ] qwk
- Meals on wls:  
  - [ ] qwk

### Assessment/Plan

### New Patient:  
- [ ] 99341
- [ ] 99342
- [ ] 99343
- [ ] 99344
- [ ] 99345

### Est Patient:  
- [ ] 99347
- [ ] 99348
- [ ] 99349
- [ ] 99350

### Patient Name:  

### MR#:  

### DOB:  

---

HYPERTENSION ENCOUNTER FORM

Patient’s name: ____________________________ Age: ________ Weight: ________ Height: ________ BMI (over): ________

History of present illness

__________________________________________________________

Major risk factors (check if present)

☐ Hypertension
☐ Tobacco use
☐ Obesity (BMI ≥ 30 kg per m^2)
☐ Physical inactivity
☐ Dyslipidemia
☐ Diabetes mellitus
☐ Microalbuminuria or glomerular filtration rate < 60 mL per minute
☐ Age > 55 years (men) or > 65 years (women)
☐ Family history of premature cardiovascular disease (men < 55 years or women < 65 years)

Target-organ damage (check if present)

☐ Left ventricular hypertrophy or chronic heart failure
☐ Angina, prior myocardial infarction, revascularization
☐ Stroke or transient ischemic attack
☐ Chronic kidney disease
☐ Peripheral arterial disease
☐ Retinopathy

Physical Examination

Bilateral blood pressure measure: Systolic blood pressure (SBP)/diastolic blood pressure (DBP)

<table>
<thead>
<tr>
<th>Right arm:</th>
<th>Left arm:</th>
</tr>
</thead>
<tbody>
<tr>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

Looking for

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Comment if abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optic fundi</td>
<td>Vascular disease</td>
<td></td>
</tr>
<tr>
<td>Carotid</td>
<td>Vascular disease</td>
<td></td>
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<tr>
<td>Abdominal</td>
<td>Vascular disease</td>
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<tr>
<td>Femoral</td>
<td>Vascular disease</td>
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<tr>
<td>Thyroid gland</td>
<td>Thyroid disease</td>
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<tr>
<td>Heart</td>
<td>Valve disease, cardiomegaly</td>
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<tr>
<td>Lungs</td>
<td>Heart failure</td>
<td></td>
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<td>Abdomen</td>
<td>Aneurysm</td>
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<tr>
<td>Aortic pulsation</td>
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<td>Mass</td>
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<tr>
<td>Lower extremity edema</td>
<td>Heart failure</td>
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<tr>
<td>Edema</td>
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</tr>
<tr>
<td>Pulses</td>
<td>Vascular disease</td>
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<tr>
<td>Leg blood pressure</td>
<td>Vascular disease</td>
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<tr>
<td>Purple striae/moon facies</td>
<td>Cushing’s disease</td>
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</tr>
<tr>
<td>Neurologic examination</td>
<td>Vascular disease</td>
<td></td>
</tr>
</tbody>
</table>

Laboratory Evaluation

Looking for end-organ damage

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Ordered</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinalysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrocardiogram</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Looking for causes of secondary hypertension

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potassium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calcium</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Looking for comorbidities

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low-density lipoproteins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-density lipoproteins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triglycerides</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hematocrit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood glucose</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Assessment/Plan

Diagnosis:

☐ Prehypertension (SBP: 120 to 139 mm Hg, or DBP: 80 to 89 mm Hg)
☐ Stage 1 hypertension (SBP: 140 to 159 mm Hg, or DBP: 90 to 99 mm Hg)
☐ Stage 2 hypertension (SBP: ≥ 160 mm Hg, or DBP: ≥ 100 mm Hg)

BP Goal:

☐ ≤ 140/90 mm Hg
☐ ≤ 130/80 mm Hg (if patient has diabetes or chronic kidney disease)
☐ Other: ____________________________

Lifestyle recommendations:

☐ Salt reduction to 2 g daily
☐ Moderation of alcohol
☐ DASH diet
☐ Weight loss
☐ Regular exercise

Drug therapy: ____________________________

Follow-up: ____________________________

Physician’s signature ____________________________
Recommendations

ACEI, ARB, diuretic, BB or CCB

Inches

Diuretic for most. May consider ACEI, ARB, BB, CCB or combination.

Diuretic for most. Usually thiazide diuretic plus ACEI or ARB, BB or CCB.

Diuretic or ACEI

BB (alternate is long acting CCB)

Angiotensin-converting enzyme inhibitors

Beta blockers

Metoprolol, 50 to 100 mg once to twice daily

Aldosterone blockers

Spironolactone, 25 to 50 mg once daily

Aldosterone antagonists

Spironolactone, 25 to 50 mg once daily

Beta blockers

Metoprolol, 50 to 100 mg once to twice daily

Aldosterone antagonists

Spironolactone, 25 to 50 mg once daily

Two-drug combination for most. Usually thiazide diuretic plus ACEI or ARB, BB or CCB.

Two-drug combination for most. Usually thiazide diuretic plus ACEI or ARB, BB or CCB.

BMI = antigens-converting enzyme inhibitor; ARB = angiotensin receptor blocker; BB = beta blocker; CCB = calcium channel blocker; AldoAnt = aldosterone antagonist.

Generic Drugs

- Diuretics
- Chlorothalidone, 12.5 to 25 mg once daily
- Hydrochlorothiazide (HCTZ), 12.5 to 50 mg once daily
- Triamterene/HCTZ, 37.5 to 75 mg/25 to 50 mg once daily

Aldosterone blockers

- Spironolactone, 25 to 50 mg once daily

Angiotensin-converting enzyme inhibitors

- Lisinopril, 10 to 40 mg once daily
- Enalapril, 2.5 to 40 mg daily, divided doses once to twice daily

Body Mass Index Calculator

<table>
<thead>
<tr>
<th>Weight Lb</th>
<th>Height Inches</th>
<th>Body Mass Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>41</td>
<td>BMI &lt; 24: Normal weight</td>
</tr>
<tr>
<td>100</td>
<td>45</td>
<td>BMI 25 to 29: Overweight</td>
</tr>
<tr>
<td>110</td>
<td>50</td>
<td>BMI 30 to 39: Obese</td>
</tr>
<tr>
<td>120</td>
<td>55</td>
<td>BMI ≥ 40: Extreme obesity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weight kg</th>
<th>Height cm</th>
<th>Body Mass Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>147</td>
<td>BMI &lt; 24: Normal weight</td>
</tr>
<tr>
<td>100</td>
<td>150</td>
<td>BMI 25 to 29: Overweight</td>
</tr>
<tr>
<td>110</td>
<td>155</td>
<td>BMI 30 to 39: Obese</td>
</tr>
<tr>
<td>120</td>
<td>160</td>
<td>BMI ≥ 40: Extreme obesity</td>
</tr>
</tbody>
</table>


Decision Support for Further Investigation

- Abnormal creatinine or severe hypertension → Consider renovascular disease.
- Hypokalemia → Consider primary aldosteronism.
- Thyroid abnormality → Consider hyperthyroidism.
- Upper but not lower extremity hypertension → Consider coarctation of aorta.
- Bruit → Consider cerebrovascular disease.
- Headache, sweating and palpitations → Consider pheochromocytoma.
- Cushingoid body habitus → Consider Cushing’s disease.
- Persistent or severe elevation → Consider medications, illicit drug use and excessive alcohol use.
- Loud snoring, obesity, gasping and daytime sleepiness → Consider sleep apnea.

Decision Support for Selection of a Drug Class

Indications

- Stage 1: No compelling indications (as listed below)
- Stage 2: No compelling indications (as listed below)

Compelling indications for certain antihypertensive drugs

- Stable angina
- Acute coronary syndrome or unstable angina
- Postmyocardial infarction
- Heart failure – asymptomatic with left ventricular dysfunction
- Heart failure – symptomatic left ventricular dysfunction
- High coronary artery disease risk
- Diabetes
- Chronic kidney disease
- Recurrent stroke prevention

ACEI = angiotensin-converting enzyme inhibitor; ARB = angiotensin receptor blocker; BB = beta blocker; CCB = calcium channel blocker; AldoAnt = aldosterone antagonist.

MEDICARE INITIAL PREVENTIVE PHYSICAL EXAMINATION ENCOUNTER FORM

Patient's name: ___________________________ Date of birth: _________ Medical record #: _________
Medicare B eligibility date: _____________ Date of exam: ___________ Date of last exam: ___________

MEDICAL/SOCIAL HISTORY
Past personal illnesses or injuries:
<table>
<thead>
<tr>
<th>Injury or illness</th>
<th>Date</th>
<th>Hospitalized?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medications, supplements and vitamins:
| Drug allergies: ________________ |
|___________________________|
| Tobacco use: ________________ |
|___________________________|
| Alcohol use: ________________ |
|___________________________|
| Drug use: ________________ |
|___________________________|

Social history notes (including diet and physical activities):
| __________________________ |
|____________________________|
|____________________________|
|____________________________|
|____________________________|

Family history notes:
| __________________________ |
|____________________________|
|____________________________|
|____________________________|
|____________________________|

DEPRESSION SCREEN
1. Over the past two weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ No
2. Over the past two weeks, have you felt little interest or pleasure in doing things? ☐ Yes ☐ No

FUNCTIONAL ABILITY/SAFETY SCREEN
1. Was the patient’s timed Up & Go test unsteady or longer than 30 seconds? ☐ Yes ☐ No
2. Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? ☐ Yes ☐ No
3. Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting? ☐ Yes ☐ No

Hearing evaluation: ____________________________

A “yes” response to any of the questions regarding depression or function/safety should trigger further evaluation.

PHYSICAL EXAMINATION
Height: ______________ Weight: ______________ Blood pressure: ______________
Visual acuity: L __________ R ______________

ELECTROCARDIOGRAM
Result: ____________________________

EVALUATIONS/REFERRALS BASED ON HISTORY, EXAM AND SCREENING: ____________________________

continued ➤
COUNSELING AND REFERRAL OF OTHER PREVENTIVE SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitations</th>
<th>Recommendation</th>
<th>Scheduled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccines</td>
<td>No deductible/no co-pay</td>
<td>Medium/high risk factors:</td>
<td></td>
</tr>
<tr>
<td>• Pneumococcal</td>
<td></td>
<td>• End-stage renal disease</td>
<td></td>
</tr>
<tr>
<td>• Influenza</td>
<td></td>
<td>• Patients with hemophilia who received Factor VIII or IX concentrates</td>
<td></td>
</tr>
<tr>
<td>• Hepatitis B (if medium/high risk)</td>
<td></td>
<td>• Clients of institutions for the mentally retarded</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Persons who live in the same house as a carrier of Hepatitis B virus</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Homosexual men</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Abusers of illicit injectable drugs</td>
<td></td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap and pelvic exams</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate cancer screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Digital rectal exam (DRE)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prostate specific antigen (PSA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fecal occult blood test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Flexible sigmoidoscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Screening colonoscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Barium enema</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes self-management training</td>
<td>Requires referral by treating physician for patient with diabetes or renal disease.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone mass measurements</td>
<td>Requires diagnosis related to osteoporosis or estrogen deficiency.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glaucroma screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical nutrition therapy for diabetes or renal disease</td>
<td>Requires referral by treating physician for patient with diabetes or renal disease.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular screening blood tests</td>
<td>Order as a panel if possible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Total cholesterol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• High-density lipoproteins</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Triglycerides</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes screening tests</td>
<td>Patient must be diagnosed with one of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fasting blood sugar (FBS) or glucose tolerance test (GTT)</td>
<td>• Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dyslipidemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Obesity (BMI ≥30 kg/m²)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Previous ID of elevated impaired FBS or GTT</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>… or any two of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Overweight (BMI ≥25 but &lt;30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Family history of diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Age 65 years or older</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• History of gestational diabetes or birth to baby weighing more than 9 pounds</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physician’s signature: ___________________________ Date: ___________________________
GROUP-VISIT DOCUMENTATION FORM

Name: _____________________________ Date: __________

For the patient
Do you struggle with any of the following associated with high blood pressure or arthritis? If so, please check and/or fill out the appropriate answers:

**High blood pressure**
- [ ] Headaches
- [ ] Bloody nose
- [ ] Fatigue
- [ ] Dizziness
- [ ] Chest pain
- [ ] Shortness of breath or breathing problems
- [ ] Swelling in your legs

**Arthritis**
- [ ] Falls
- [ ] Problems getting up/out of a chair
- [ ] Problems walking
- [ ] Problems walking without use of a walker or cane
- [ ] Pain in your shoulders
- [ ] Pain in your hips
- [ ] Pain in your knees
- [ ] Pain in your hands
- [ ] Pain in other joints: _____________________________

Is there anything else you need the doctor to know?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

For the doctor
BP: _____________________________ HR: __________________________
Heart: __________________________ Lungs: __________________________ Edema: __________________________
Ambulation: [ ] normal [ ] hesitant [ ] wobbling [ ] needs device [ ] needs assist
Sitting to standing: [ ] normal (no arms) [ ] slow without use of arms/with use of arms/with devices
Get up and go: [ ] < 20 seconds [ ] 20-29 seconds [ ] > 30 seconds
Overall fall risk: [ ] none [ ] small [ ] moderate [ ] significant
ROM of knees: [ ] normal [ ] limited [ ] markedly limited
    of hips: [ ] normal [ ] limited [ ] markedly limited
Hands: [ ] Heberden’s nodes [ ] ulnar deviation [ ] bony enlargement

PERTUSSIS SCREENING FORM

Patient Name: _____________________________ Date: ______________ Date of Birth: ______________

☐ Inform patient of exposure  ☐ Review chart

Is the patient newly symptomatic (congestion, runny nose, fever, cough) since the exposure?

☐ No  ☐ Yes  If yes, describe: whoop/paroxysmal/prolonged cough/post-tussive emesis/apnea/other: ______________________

☐ Note time of onset: ______________________

☐ Recommend medical evaluation/treatment

Was anyone with the patient in the exam room at the time of visit?

☐ No  ☐ Yes  If yes, name: ______________________

☐ Not our patient: Refer for preventive treatment.


☐ Document in patient’s chart

☐ Inform patient of treatment options.

Does patient have antibiotic allergies?

☐ No  ☐ Yes  If yes, list: ______________________

Select prophylactic treatment:

☐ Biaxin XL 500 mg: Two tablets by mouth every day for 14 days. Disp#28 Ref#0

☐ Erythromycin 500 mg: One tablet by mouth every 6 hours for 14 days. Disp#56 Ref#0

☐ Septra DS (TMP = 160 mg per tablet): One tablet by mouth twice daily for 14 days. Disp#28 Ref#0

☐ Zithromax Zpack: As directed for 5 days. Disp#1 Ref#0

Second-line therapy:

☐ Doxycycline 100 mg by mouth twice daily for 14 days. Disp#28 Ref#0

☐ Levaquin 500 mg: One tablet by mouth daily for 7 days. Disp#7 Ref#0

Pediatric dosing:

Weight = _____________ kg

☐ Biaxin suspension: 15-20 mg/kg/day orally, in 2 divided doses for 7 days. (Maximum 1 g/day)

☐ Erythromycin estolate: 40-50 mg/kg/day orally, in 4 divided doses for 14 days. (Maximum 2g/day)

☐ Septra/Bactrim suspension: 8 mg/kg/day (based on TMP) orally, in two divided doses for 14 days.

☐ Zithromax suspension: 10-12 mg/kg/day orally, once daily for 5 days. (Maximum 600 mg/day)

Pediatric Rx:

☐ Call pharmacy: ______________________

☐ Caution patient to be checked if symptoms develop.

☐ Answer patient's questions.

Caller signature __________________________________________

Physician signature __________________________________________ MD/CRNP

## PULMONARY EMBOLISM ENCOUNTER FORM

**Patient’s name:** ____________________________ **Age:** ________ **Medical record #:** ____________

### Data collection:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Clinical signs and symptoms of deep venous thrombosis (DVT; leg swelling and pain with palpation of the deep veins)</td>
<td>3.0</td>
</tr>
<tr>
<td>□ Pulmonary embolism (PE) as likely or more likely than an alternative diagnosis (based on the history and physical examination, chest radiography, electrocardiogram, and any blood tests that were considered necessary)</td>
<td>3.0</td>
</tr>
<tr>
<td>□ Heart rate &gt; 100 beats per minute</td>
<td>1.5</td>
</tr>
<tr>
<td>□ Immobilization (bed rest, except to access the bathroom, for at least 3 consecutive days) or surgery in the previous 4 weeks</td>
<td>1.5</td>
</tr>
<tr>
<td>□ Previous objectively diagnosed DVT or PE</td>
<td>1.5</td>
</tr>
<tr>
<td>□ Hemoptysis</td>
<td>1.0</td>
</tr>
<tr>
<td>□ Malignancy (treatment that is ongoing, within the past 6 months, or palliative)</td>
<td>1.0</td>
</tr>
</tbody>
</table>

**Total points:**

- Risk score interpretation:
  - < 2 points: low risk (1.3 percent)
  - 2 to 6 points: moderate risk (16.2 percent)
  - > 6 points: high risk (40.6 percent)

### Other important data:

- □ Known thrombophilia
- □ Pregnant

Other information from the history and physical examination:

__________________________________________

__________________________________________

**Assessment/plan:**

- **Low-risk patient:**
  - Order d-dimer assay (at least 85% sensitive):
    - d-dimer negative: PE ruled out.*
    - d-dimer positive: Go to protocol for moderate- or high-risk patient.

- **Moderate-risk patient: or** **High-risk patient:**
  - Order d-dimer test and either ventilation-perfusion (V/Q) scan or helical computed tomographic (CT) scan (the latter is preferred if the patient has chronic pulmonary disease):
    - Normal V/Q scan: PE ruled out.†
    - High-probability V/Q scan or positive helical CT scan‡: PE diagnosed.
    - Nearly normal V/Q scan, low- or intermediate-probability V/Q scan, or any other helical CT result. Order bilateral ultrasound of leg veins:
      - Positive ultrasound examination: PE diagnosed.
      - Negative ultrasound examination. Base further evaluation on initial clinical risk assessment:
        - Low-risk patient: PE ruled out.
        - Moderate-risk patient and negative d-dimer test: PE ruled out.
        - High-risk patient and positive d-dimer test: PE ruled in (consider angiogram to confirm diagnosis).
        - Moderate-risk patient and positive d-dimer test, or high-risk patient and negative d-dimer test. Choose one of the following options and manage according to the results:
          - Serial ultrasound at 1 and 2 weeks:
              - Positive
              - Negative
          - Helical CT scan (if not already ordered):
              - Positive
              - Negative§
          - V/Q scan (if not already ordered):
              - Positive
              - Negative§
          - Pulmonary angiography||:
              - Positive
              - Negative

*—Less than 2 percent PE with moderately sensitive d-dimer test (85 to 98 percent) and less than 1 percent PE with highly sensitive d-dimer test (greater than 98 percent).
†—Approximately 1 percent with PE.
‡—Positive helical CT indicates intraluminal filling defects in segmental or larger pulmonary arteries.
§—Consider serial bilateral ultrasound examination of proximal leg veins in patients with negative results.
||—Preferred in the following instances: if a subsegmental intraluminal filling defect is seen on initial helical CT scan; if there is a high-probability V/Q scan in a low-risk patient; if serial testing is not feasible; or if symptoms are severe and there is a need to exclude PE from the differential diagnosis.

---

COMMON SKIN PROCEDURE FORM

Patient name ___________________________ Date of birth ____________ Medical record # ____________

Patient’s complaint: ________________________________

_________________________________________________________________________________________

Treatment performed:

☐ Laceration repair
   Location: ____________________________
   Length (circle one): <2.6 cm | 2.6–5.0 cm | 5.1–7.5 cm | 7.6–12.5 cm | 12.6–20.0 cm | 20.1–30.0 cm | >30.0 cm
   Closure (circle one):
       Simple – single layer, no debridement | Intermediate – deep layers or single layer with debridement
       Complex – significant debridement or undermining | Reconstructive – e.g., Z-plasty

☐ Excision (lesion completely removed)
   Location: ____________________________
   Size (lesion diameter + both margins; circle one): <0.6 cm | 0.6–1.0 cm | 1.1–2.0 cm | 2.1–3.0 cm | 3.1–4.0 cm | >4.0 cm
   Pathology (circle one): Benign | Malignant
   Closure (circle one): Simple | Intermediate | Complex | Reconstructive
   If closure is other than simple, a separate additional code should be reported.

☐ Shave (does not penetrate fat, no suturing needed)
   Location: ____________________________
   Lesion diameter (circle one): <0.6 cm | 0.6–1.0 cm | 1.1–2.0 cm | >2.0 cm

   For the CPT codes for laceration repair, excision and shaving, refer to the current CPT manual.

☐ Biopsy (only part of lesion is removed)
   ☐ Biopsied one lesion. Code 11100
   ☐ Biopsied additional lesions. (For each additional lesion, code 11101.) Code 11101 ______ time(s)

☐ Plantar wart, common wart and keratosis destruction
   ☐ Destroyed one lesion. Code 17000
   ☐ Destroyed up to 13 additional lesions. (For each one, code 17003.) Code 17003 ______ time(s)
   ☐ Destroyed 15 or more lesions. Code 17004 only

☐ Flat wart and molluscum contagiosum destruction
   ☐ Destroyed up to 14 lesions. Code 17110
   ☐ Destroyed 15 or more lesions. Code 17111 only

☐ Skin tags
   ☐ Removed up to 15 skin tags. Code 11200
   ☐ Removed additional tags. (For each additional 10 lesions, code 11201.) Code 11201 ______ time(s)

☐ Nails
   ☐ Trimmed any number of nondystrophic nails. Code 11719
   ☐ Debridement of one to five dystrophic nails. Code 11720
   ☐ Debridement of six or more dystrophic nails. Code 11721

Reason for treatment/Notes: ________________________________

_________________________________________________________________________________________

Physician signature ___________________________ Date ____________

### Sore Throat Encounter Form

**Patient’s name:** ____________________________  **Age:** ______  **Medical record #:** ____________________________

#### Data collection:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of fever or measured temp &gt;100.4°F</td>
<td>1</td>
</tr>
<tr>
<td>Absence of cough</td>
<td>1</td>
</tr>
<tr>
<td>Tender anterior cervical nodes</td>
<td>1</td>
</tr>
<tr>
<td>Tonsillar swelling or exudates</td>
<td>1</td>
</tr>
</tbody>
</table>

**Patient’s age**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;15 years</td>
<td>1</td>
</tr>
<tr>
<td>15 to 45 years</td>
<td>0</td>
</tr>
<tr>
<td>&gt;45 years</td>
<td>-1</td>
</tr>
</tbody>
</table>

**Total:**

**Score:**

- 0 to -1 point: Strep throat ruled out (only a 2% risk).
- 1 to 3 points: Order rapid strep test; treat accordingly.
- 4 to 5 points: Diagnose probable strep throat (52% risk); consider empiric antibiotic therapy.

### Suggestive findings

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Points</th>
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<tbody>
<tr>
<td>Palatine petechiae or scarlatiniform rash</td>
<td></td>
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<tr>
<td>Contact with strep infection in past 2 weeks</td>
<td></td>
</tr>
<tr>
<td>Duration of illness &lt; 3 days</td>
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<tr>
<td>Headache</td>
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<tr>
<td>Petechial rash</td>
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<tr>
<td>Stiff neck</td>
<td></td>
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<tr>
<td>Hot-potato voice</td>
<td></td>
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<tr>
<td>Sudden/severe symptoms</td>
<td></td>
</tr>
<tr>
<td>Posterior cervical adenopathy or teenager</td>
<td></td>
</tr>
</tbody>
</table>

### Diagnostic considerations

- Palatine petechiae or scarlatiniform rash: Probable strep throat
- Contact with strep infection in past 2 weeks: Consider strep throat
- Duration of illness < 3 days: Consider strep throat
- Headache: Consider meningitis
- Petechial rash: Consider meningitis
- Stiff neck: Consider meningitis
- Hot-potato voice: Consider abscess
- Sudden/severe symptoms: Consider abscess
- Posterior cervical adenopathy or teenager: Consider mononucleosis

#### Rapid strep test:

- Positive
- Negative
- NA

#### Mono spot test:

- Positive
- Negative
- NA

#### Other history:

- ____________________________

### Diagnosis:

- Probable or confirmed strep throat
- Viral pharyngitis
- Mononucleosis
- Other: ____________________________

### Antibiotic treatment:

- None needed
- Penicillin V potassium
- Cephalexin
- Erythromycin
- Azithromycin

### Symptomatic measures:

- NSAID
- 2% lidocaine gargle
- Sore throat spray
- Salt water gargles
- Follow-up visit:
  - prn only
  - ____________ days

### Other treatment:

- ____________________________

- Patient education handout given.
UPPER RESPIRATORY INFECTION EXAM

Name: ____________________________ Age: _______ Date: __________

Patient section
Please answer the following questions. This will help your physician identify possible problems.

Do you have a runny nose? □ Yes □ No
If "yes," describe the nature of drainage:
□ clear □ yellow/green □ white □ thick □ bloody

Do you have any nasal congestion? □ Yes □ No
Do you have any sinus pain? □ Yes □ No
Do you have post nasal drip? □ Yes □ No
Are your eyes: □ red? □ watery? □ itchy?

Do you have ear pain? □ Yes □ No
Do you have a fever? □ Yes □ No
Do you have nausea? □ Yes □ No
Have you vomited? □ Yes □ No
Do you have diarrhea? □ Yes □ No
Do you have a sore throat? □ Yes □ No
Are you achy? □ Yes □ No
Do you have any pain? □ Yes □ No
If "yes," rate your level of pain:
None 0 1 2 3 4 5 6 7 8 9 10 Severe

Do you have any rashes? □ Yes □ No
Do you have a cough? □ Yes □ No
If "yes," describe your cough:
□ dry □ productive
Nature of sputum, if any:
□ clear □ yellow/green □ white □ thick □ bloody

Do you have asthma? □ Yes □ No
Do you use tobacco? □ Yes □ No

Other symptoms: __________________________________________________________

Do you have any allergies? __________________________________________________

How long have you felt sick? ________________________________________________

What medicines have you tried? (Include herbal or over-the-counter medicines.) __________________________________________________________

Was there any improvement? ______________________________________________

Do you need a work note? □ Yes □ No
Do you need other medicine refilled? □ Yes □ No

Provider section

CC: ______________________________________________________________

HPI: □ Patient history reviewed ____________________________________________

Exam: □ Well-developed/well-nourished; no acute distress
□ Vital signs: See flow sheet in chart

Normal Abnormal

Ears

□ □

Eyes

□ □

Nose

□ □

Sinuses

□ □

Pharynx

□ □

Nodes

□ □

Lungs

□ □

Heart

□ □

Abdomen

□ □

Other

□ □

Assessment

□ Acute bronchitis 466.0 □ Otitis externa 380.10 □ Pneumonia 486
□ Allergic rhinitis 477.9 □ Otitis media 382.9 □ Sinusitis 461.9
□ Asthma 493.90 □ Otitis media, serous 381.10 □ Strep 034.0
□ Conjunctivitis 372.00 □ Flu 487.1 □ URI 465.9

Plan:
□ Strep test: □ (+), see antibiotics below □ (-), do culture and sensitivity
□ Chest X-ray

Over-the-counter drugs:
□ Claritin □ Claritin D bid □ Sudafed prn □ Other: ______________________

Prescription drugs:
□ Allegra: 60mg bid or 180mg/day
□ Zyrtec: 10mg/day
□ Phenergan VC with Codeine: 1-2 tsp q 4 hr
□ Other: ______________________________________________________________

Antibiotics:
□ Amoxil: □ 250mg, □ 500mg or □ 200/5mL □ bid or □ tid
□ Augmentin: □ 250mg, □ 500mg or □ 875mg □ bid or □ tid
□ Erythromycin: □ 250mg, □ 333mg or □ 500mg □ bid or □ tid
□ Zithromax □ Zithromax Tri-Pak □ Tessalon Perles 100mg qid
□ Other: _____________________________________________________________

Patient education? □ Yes □ No

Follow up: □ prn or _______ week(s) or _______ month(s)

Off work or school from _________ to ___________

Physician/provider signature ____________________________ Date __________

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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: _______

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 □ a lot □ some □ few
      Vegetables □ a lot □ some □ few
      Dairy foods □ a lot □ some □ few
      Meats □ a lot □ some □ few
      Sweets □ a lot □ some □ 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 was your last dental check-up? ___________

8. Please describe any concerns you have:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Thank you for your help.
Date: ___________________

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<th>Height</th>
<th>Weight</th>
<th>Overweight</th>
<th>BP</th>
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<tr>
<td></td>
<td></td>
<td>□ YES □ NO</td>
<td></td>
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</tbody>
</table>

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 Rx □ 600 mg/d □ 1200 mg/d
  - ☐ PSA (controversial)

Follow-Up:

- ☐ Routine visit in _____________ for ________________
- ☐ Physical exam in ________________

Name: ___________________________________________        Physician signature: ________________________________
DOB: _____/_____/______        Physician name: __________________________________
Chart #: _________________________

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WELL-WOMAN EXAM

Patient’s Name __________________________

**Patient section**

Please answer the following questions. This will help your physician identify possible problems.

Your age: __________________________

When was your last mammogram? ________________

When was your last PAP test? □ 1 yr □ 2 yrs □ >3yrs

Were the results normal? □ Yes □ No

Have you ever had an abnormal PAP test? □ Yes □ No

How often do you usually get your period? every ___ days

Are your periods usually regular? □ Yes □ No

How many days do your periods usually last? ___ days

The blood flow is: □ Light □ Moderate □ Heavy

Do you have any bleeding between periods? □ Yes □ No

Do you have any vaginal discharge? □ Yes □ No

Are you sexually active? □ Yes □ No

If yes, do you and your partner use birth control? □ Yes □ No  Method: __________________________

Have you ever had a sexually transmitted disease? □ Yes □ No

Has your mother ever been exposed to DES? □ Yes □ No

Have you ever used fertility medicines? □ Yes □ No

Do you have hot flashes? □ Yes □ No

Do you smoke? □ Yes □ No

Are you on hormone replacement? □ Yes □ No

Do you feel safe? □ Yes □ No

Is there any family history of:

Breast cancer? □ Yes □ No

Colon cancer? □ Yes □ No

Uterine cancer? □ Yes □ No

Ovarian cancer? □ Yes □ No

Other cancers? □ Yes □ No

Osteoporosis? □ Yes □ No

Heart disease? □ Yes □ No

Do you have any allergies? □ Yes □ No  (list them below)

On a scale of 0 to 10, with 0 being no symptoms and 10 being severe symptoms, how would you describe the following (please circle):

Pain during your usual period:

0 1 2 3 4 5 6 7 8 9 10

Pain during sex:

0 1 2 3 4 5 6 7 8 9 10

PMS (premenstrual tension syndrome):

0 1 2 3 4 5 6 7 8 9 10

If you have been pregnant, please indicate how many:

Pregnancies _____  Abortions _____  Living children _____

Full-term live births _____  Premature births _____

Please list any other concerns: __________________________

**Physician section:**

Abnormals should be described below or on the reverse side of this form. For VS and allergies, see separate note in chart.

<table>
<thead>
<tr>
<th>Abnorm</th>
<th>Abnorm</th>
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<tbody>
<tr>
<td>HEENT</td>
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<td>THYROID</td>
<td>SKIN</td>
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<tr>
<td>LUNGS</td>
<td>EXTREMITIES</td>
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<tr>
<td>HEART</td>
<td>NEURO</td>
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If there are any abnormalities, circle the specific one(s) and describe below or on reverse.

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<thead>
<tr>
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<tbody>
<tr>
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<td>Discharge</td>
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<tr>
<td>Size</td>
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<th>Abnorm</th>
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<tbody>
<tr>
<td>ACETIC ACID WASH</td>
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</tbody>
</table>

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A: □ Normal gyn/pap □ Family planning □ Pregnancy □ HRT

P: □ Pap □ HRT info given □ Caffeine ed □ Stool OB

□ BSE info □ Flex sig □ Calcium ed

□ Mammogram □ Dexa □ Heel □ Full

Return for pap 1 year or __________ RTC __________

---

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 YES ________ NO ________
   Estrogen (Premarin) YES ________ NO ________
   Progesterone (Provera) YES ________ 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 YES ________ NO ________
      Biopsies YES ________ NO ________
      Surgery YES ________ 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 ________ NO ________
   If 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 YES ________ NO ________
      Broken hip or wrist YES ________ NO ________
      Bone-density test YES ________ NO ________
   c. Do you take any of the following:
      Steroids (prednisone) YES ________ NO ________
      Medication for thyroid, seizures or thin bones YES ________ 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 ________

continued ➤
9. 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

10. Prevention:
   a. Which of the following are included in your diet:
      - Grains and starches □ a lot □ some □ few
      - Vegetables □ a lot □ some □ few
      - Dairy foods □ a lot □ some □ few
      - Meats □ a lot □ some □ few
      - Sweets □ a lot □ some □ 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? □ 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. Have you ever had a mammogram? □ YES □ NO
      If yes, date of last: _______ where: __________________
      Have you ever had any abnormal mammograms? □ N/A □ YES □ NO
      If yes, date: _______ problem: __________________
   i. Have you had a tetanus shot in the past 10 years? □ YES □ NO
   j. When is the last time you had a dental check-up? _______

11. Please describe any concerns you have:
    __________________________________________________________
    __________________________________________________________
    __________________________________________________________
    __________________________________________________________
    __________________________________________________________
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Thank you for your help.
WELL-WOMAN EXAM

Date: ________________________

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<th>Weight</th>
<th>Overweight</th>
<th>BP</th>
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<td>□ YES □ NO</td>
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If necessary

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<th>Pulse</th>
<th>Resp</th>
<th>O₂ Sat</th>
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ALLERGIES

Other complaints/hpi:
__________________________________________________________________________________________
__________________________________________________________________________________________

Physical exam:

Oral exam (if smoker): Normal Abnormal: ________________________

Vaginal: Normal Abnormal: ________________________

Ext. genitalia: Normal Abnormal: ________________________

Cervix: Normal Abnormal: ________________________

Uterus and adnexa: Normal Abnormal: ________________________

Breasts:

Normal Abnormal: (no masses; no skin, nipple or axillary changes)

Ext. genitalia: Normal Abnormal: ________________________

Cervix: Normal Abnormal: ________________________

Uterus and adnexa: Normal Abnormal: ________________________

Breasts: Normal Abnormal: ________________________

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

HEENT: Normal Abnormal: ________________________

Heart: Normal Abnormal: ________________________

Lungs: Normal Abnormal: ________________________

Rectum: Normal Abnormal: ________________________

Abdomen: 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

☐ Pap smear

☐ Folic acid Rx

☐ Calcium Rx: □ 600mg/d □ 1200mg/d

☐ Immunizations: flu, Td (q 10 yrs)

☐ Recommended dental exam

☐ Other:

Over 40 y/o:

☐ Mammogram( controversial 40-50 y/o, consider q 2 yrs)

Over 50 y/o:

☐ Reminded to report postmenopausal bleeding

☐ Cholesterol

☐ Hormone replacement: ☐ estrogen 0.___ mg/d ☐ progesterone 2.5mg/d

☐ Colon cancer screen: ☐ colonoscopy ☐ ACBE ☐ flex sig ☐ stool guaiac x 3

☐ Bone density

☐ Coated ASA: □ 325 mg/d □ 81 mg/d

☐ Immunizations: pneumococcal (>65 y/o)

Follow-Up:

☐ Routine visit in ________________________ for ________________________

☐ Physical exam in __________

Name: ________________________

DOB: ________/______/______

Chart #: ________________________

Physician signature: ________________________

Physician name: ________________________