Name: _____ Date: _____

DOB: _____ H: _____ W: _____ T: _____ P: _____ BP: _____ R: _____

Nurse's Note: _____

_____

HPI
Location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms OR status of chronic diseases.

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

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

Exam	nl	See note
Const	❑	❑
Eyes	❑	❑
ENT/mouth	❑	❑
Neck	❑	❑
Resp	❑	❑
CV	❑	❑
Chest (breasts)	❑	❑
GI (abdomen)	❑	❑
Lymph	❑	❑
GU	❑	❑
Musc	❑	❑
Skin	❑	❑
Neuro	❑	❑
Psych	❑	❑

No ✔: no review/exam

CC:

HPI:

Couns/coord > 50% ❑

Total time: _____ min.

Physician's Signature: _____ Couns/coord time: _____ min.

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