

# E/M VISIT ENCOUNTER FORM

HPI		
Location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms.		
ROS	WNL	SEE NOTE
Const	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>
ENT/mouth	<input type="checkbox"/>	<input type="checkbox"/>
CV	<input type="checkbox"/>	<input type="checkbox"/>
Resp	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>
Musc	<input type="checkbox"/>	<input type="checkbox"/>
Skin/breasts	<input type="checkbox"/>	<input type="checkbox"/>
Neuro	<input type="checkbox"/>	<input type="checkbox"/>
Psych	<input type="checkbox"/>	<input type="checkbox"/>
Endo	<input type="checkbox"/>	<input type="checkbox"/>
Hem/lymph	<input type="checkbox"/>	<input type="checkbox"/>
Allerg/immun	<input type="checkbox"/>	<input type="checkbox"/>
No noteworthy changes since last visit. See note dated: <div style="background-color: #cccccc; width: 100px; height: 15px; margin: 5px 0;"></div> /      /		
PFSH	NO CHNG	SEE NOTE
Past	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>
Social	<input type="checkbox"/>	<input type="checkbox"/>
No noteworthy changes since last visit. See note dated: <div style="background-color: #cccccc; width: 100px; height: 15px; margin: 5px 0;"></div> /      /		
EXAM	WNL	SEE NOTE
Const	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>
ENT/mouth	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>
Resp	<input type="checkbox"/>	<input type="checkbox"/>
CV	<input type="checkbox"/>	<input type="checkbox"/>
Chest (breasts)	<input type="checkbox"/>	<input type="checkbox"/>
GI (abdomen)	<input type="checkbox"/>	<input type="checkbox"/>
Lymph	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>
Musc	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Neuro	<input type="checkbox"/>	<input type="checkbox"/>
Psych	<input type="checkbox"/>	<input type="checkbox"/>
No ✓ : no review/exam		

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ H: \_\_\_\_\_ W: \_\_\_\_\_ T: \_\_\_\_\_ P: \_\_\_\_\_ BP: \_\_\_\_\_ R: \_\_\_\_\_

Nurse's Note: \_\_\_\_\_

CC: \_\_\_\_\_

HPI: \_\_\_\_\_

Couns/coord > 50%

Total time: \_\_\_\_\_ min.

Couns/coord time: \_\_\_\_\_ min.

Physician's Signature: \_\_\_\_\_



**FPM Toolbox** To find more practice resources, visit <https://www.aafp.org/fpm/toolbox>.

Developed by the editors of *FPM*. Copyright © 1995, 1998 American Academy of Family Physicians. Physicians may duplicate or adapt for use in their own practices; all other rights reserved. Related article: <https://www.aafp.org/fpm/2003/1000/p51.html>.