

GROUP-VISIT ENCOUNTER FORM (NURSING HOME)

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	Arthritis
<input type="checkbox"/> Headaches	<input type="checkbox"/> Falls
<input type="checkbox"/> Bloody nose	<input type="checkbox"/> Problems getting up/out of a chair
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Problems walking
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Problems walking without use of a walker or cane
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Pain in your shoulders
<input type="checkbox"/> Shortness of breath or breathing problems	<input type="checkbox"/> Pain in your hips
<input type="checkbox"/> Swelling in your legs	<input type="checkbox"/> Pain in your knees
	<input type="checkbox"/> Pain in your hands
	<input type="checkbox"/> 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



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

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