DOCUMENTING HISTORY AT A GLANCE

Established Patient Office Visit

Code	History	Examination	Medical Decision Making	Time
99211	—	—	—	5 min.
99212	Problem focused	Problem focused	Straightforward	10 min.
99213	Expanded problem focused	Expanded problem focused	Low complexity	15 min.
99214	Detailed	Detailed	Moderate complexity	25 min.
99215	Comprehensive	Comprehensive	High complexity	40 min.
	2 of 3 required			

Type of History	History of the Present Illness (HPI)
Problem focused	**Brief** One to three elements
Expanded problem focused	**Brief** One to three elements
Detailed	**Extended** Four or more elements (OR status of three or more chronic or inactive conditions)
Comprehensive	**Extended** Four or more elements (OR status of three or more chronic or inactive conditions)

New Patient Office Visit

Code	History	Exam	Medical Decision-Making	Time
99201	Problem focused	Problem focused	Straightforward	10 min.
99202	Expanded problem focused	Expanded problem focused	Straightforward	20 min.
99203	Detailed	Detailed	Low complexity	30 min.
99204	Comprehensive	Comprehensive	Moderate complexity	45 min.
99205	Comprehensive	Comprehensive	High complexity	60 min.
	3 of 3 required			

The History of the Present Illness is a chronological description of the development of the patient's present illness from the first sign or symptom or from the previous encounter to the present. It may include the following elements:

- Location,
- Quality,
- Severity,
- Duration,
- Timing,
- Context,
- Modifying factors,
- Associated signs and symptoms,
- The status of chronic or inactive conditions.

Review of Systems

- Constitutional symptoms (e.g., fever, weight loss),
- Eyes,
- Ears, nose, mouth, throat,
- Cardiovascular,
- Respiratory,
- Gastrointestinal,
- Genitourinary,
- Musculoskeletal,
- Integumentary (skin and/or breast),
- Neurologic,
- Psychiatric,
- Endocrine,
- Hematologic/lymphatic,
- Allergic/immunologic.

Review of Systems (ROS)	Past, Family and/or Social History (PFSH)
Not required	Not required
Problem pertinent Positive and pertinent negative responses for the system directly related to the problem(s) identified in the HPI.	Not required
Extended Positive and pertinent negative responses for 2 to 9 systems.	**Pertinent** At least one specific item from the PFSH must be documented.
Complete Positive and pertinent negative responses for at least 10 systems, including the one directly related to the problem identified in the HPI. Systems with positive or pertinent negative responses must be documented individually. For the remaining systems, a notation indicating that all other systems are negative is permissible.	**Complete** At least one item from each of two areas must be documented for most services to established patients. (At least one item from each of the three areas must be documented for most services to new patients.)
3 of 3 required	

The guidelines recognize three areas of **Past, Family and/or Social History:**

Past History
A review of current medications, prior illnesses and injuries, operations and hospitalizations, allergies and age-appropriate immunization status.

Family History
A review of significant medical information about the patient's family, including information about the health status or cause of death of parents, siblings and children; specific diseases related to problems identified in the CC, HPI or ROS.

Social History
An age-appropriate review of significant activities that may include information such as marital status, living arrangements, occupational history, use of drugs, alcohol or tobacco, extent of education and sexual history.