Encounter Forms for Better Preventive Visits

These two tools can help improve your care and documentation.

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CME Covered in *FPM* Quiz

FPM Tool inside

The foundation of disease prevention is identifying the patients' conditions and the effective interventions available. This takes a long time using traditional history-taking, which leaves less visit time for other issues. Many traditional comprehensive history forms include issues that are not associated with evidenced-based interventions. And even when a physician makes a special effort to keep up with proven screening test recommendations, it is difficult to remember all the recommendations that apply to a specific patient.

To address these issues, I developed comprehensive tools that include a patient-completed history, exam documentation template and evidence-based screening test recommendations for all age groups. The tools, which appear on page 36 and can be downloaded online at www.aafp.org/fpm/20030700/35enco.html, can be modified to conform to specific practice parameters or changes in disease-prevention recommendations.

How they work

Patients complete the history section, which is structured to allow what for most reasonably healthy patients will be a brief review by the physician. Standard medical and family history questions are included as well as questions about common issues that we often forget to ask about, such as sexual and urinary function, depression, sleep problems and addictions. All of the questions are written at an upper elementary level, but physicians should direct staff members to be sensitive to those patients who may not be able to read or completely understand the questions.

Physicians and other providers complete the last page of the forms. Practices can decide whether to attach this last page to the rest of the encounter form before or after the patient fills out the history section. A small amount of space at the top is designated for documentation of additional history. If the additional history relates specifically to one of the questions on the history portion of the forms, it may be easier to document it in the margin near the appropriate question. The physical exam items can be completed quickly by circling "normal" or "abnormal" and noting any specific abnormalities. Below the exam items, space is also provided for diagnoses and any associated plans that are not preventive. Finally, the "plan" section lists diagnostic and therapeutic preventive service recommendations from the U.S. Preventive Services Task Force, grouped by age where appropriate.

The concern has been raised that this form's extensive screening medical history will lead to a lengthy office visit. However, I've not found that to be the case. If time permits, a minor issue can be dealt with as part of the preventive visit. Otherwise, the patient can return for a follow-up visit, or visits, to more extensively address any additional problems. Because the specific items on the encounter form are scientifically well supported, any additional visits generated by the form will be appropriate.

The benefits

After using these preventive-visit encounter forms in my practice, I found that they simultaneously save time and improve patient flow, documentation and quality of care. Having patients complete their own, extensive medical history gives them something productive to do during a portion of their waiting time, promotes more honest answers and provides an effective illness identification tool. Visits are shorter or, in some cases, allow enough time for educating patients on unhealthy behaviors and chronic diseases that are often not adequately addressed. The encounter forms also make documentation more complete and improve the quality of the preventive care by reminding the physician to order the most up-to-date, evidence-based interventions. ➤

Send comments to fpmedit@aafp.org.

Dr. Cardinal is the vice president of medical affairs at Gettysburg Hospital, a 100-bed community hospital in Gettysburg, Pa. Previously, he oversaw a practice network with more than 300,000 visits per year. Conflicts of interest: none reported.

ILLUSTRATION BY STEPHAANIE CARTER

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 in the next 6-12 months? ❍ YES ❍ NO

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: _____

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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

Form continues on next page ➤

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? ❍ 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. 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: _____

      For abnormality, did you have any of the following:

Biopsy	❍ YES	❍ NO
Cyst fluid drained	❍ YES	❍ NO
Surgery	❍ YES	❍ NO

   i. How many sexual partners have you had in the last 12 months? ____ In your lifetime? ____
   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.

Continued ➤

WELL-WOMAN EXAM

Date: _____

Height	Weight	Overweight	BP
		❍ YES ❍ NO	

If necessary				ALLERGIES
Temp	Pulse	Resp	O_2 Sat	

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)

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 R_x
- ❍ Calcium R_x: ❍ 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: _____ Physician signature: _____

DOB: _____/_____/_____ Physician name: _____

Chart #: _____

FAMILY PRACTICE MANAGEMENT

WELL-MALE EXAM

FPM Tool

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: _____

   When are you planning to quit?

   ❍ now ❍ next 6 months ❍ sometime ❍ never

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
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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 is the last time you had a dental check-up?_____

8. Please describe any concerns you have:

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your help.

Continued ➤

WELL-MALE EXAM

Date: _____

Height	Weight	Overweight	BP
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If necessary				ALLERGIES
Temp	Pulse	Resp	O_2 Sat	

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 R_x: ❍ 600 mg/d ❍ 1200 mg/d
❍ PSA (controversial)

Follow-Up:

❍ Routine visit in _____ for _____
❍ Physical exam in _____

Name: _____ Physician signature: _____

DOB: _____/_____/_____ Physician name: _____

Chart #: _____

FAMILY PRACTICE MANAGEMENT