ACOG WOMAN'S HEALTH RECORD

HOW TO USE THE ACOG WOMAN'S HEALTH RECORD

SAMPLE

The ACOG Woman's Health Record is intended to serve as a complete record for a woman's gynecologic care. It allows documentation of both preventive services and services directed to a chief complaint. This record has been specifically designed to aid in documentation and correct coding of women's health services.

The recommendations contained in the ACOG Woman's Health Record may be subject to change by subsequently released ACOG guidelines. The ACOG Woman's Health Record includes:

- Form A—Physician History
- Form B—Patient Intake History
- Form C—Problem List/Immunization Record/Routine and High-Risk Screening Records

Form A—Physician History includes:

Physician History: The Physician History can be used to record the history for every type of outpatient encounter, including consultations. A new Physician History should be completed by the physician at each visit when clinically indicated.

Physical Examination: The Physical Examination section should be completed by the physician each time a physical examination is provided. The form offers prompts to aid in documenting the services that are provided. This form is based on the 1997 CMS (formerly, HCFA) guidelines for the female genitourinary system examination and can be used to document any level of examination.

Medical Decision Making: The Medical Decision Making section provides space to document minutes counseled, total encounter time, and other services needed to determine the correct level of medical decision making.

Form B–Patient Intake History is an optional form giving practices the flexibility to have patients complete their own history at or before the visit. It uses language that a patient is likely to understand and includes ample space for physician notes. Space at the end of the form allows physicians to review the history and sign off for 4 years. At year 5, the patient should be asked to complete a new Patient Intake History.

Form C includes:

Problem List and Immunization Record: The Problem List captures problems, allergies, family history, and current medication use. The Immunization Record lists immunization services recommended by ACOG for either routine use or in high-risk patients, as defined in the enclosed table of high-risk factors. Ample space for listing problems and immunization services allows the same form to be used for years.

Routine and High-Risk Screening Records: The Routine and High-Risk Screening Records provide ample space to document laboratory and other screening services. The Routine Screening Record includes those screening tests recommended by ACOG for routine use and provides reminders for recommended frequency of services. The High-Risk Screening Record includes those screening tests recommended by ACOG on the basis of the risk factors defined in the enclosed table of high-risk factors.

The ACOG Woman's Health Record also includes helpful reference information (one each per package):

Coding Tips: This sheet includes all the reminders a physician needs to code correctly the history, physical examination, and medical decision making provided during the visit. Once these elements have been coded correctly, the summary tables can be used to select the appropriate code for the visit.

Table of High-Risk Factors: The table (see back of this card) lists in one place the risk factors that should prompt recommended interventions, laboratory tests, and immunizations. It is to be used in completing the Immunization Record and the Routine and High-Risk Screening Records.

HIGH-RISK FACTORS

Intervention	High-Risk Factor
Bacteriuria testing	Diabetes mellitus
Bone density screening*	Postmenopausal women younger than 65 years: personal history of fracture as an adult; history of fracture in a first-degree relative; Caucasian; dementia; poor health or frailty; current cigarette smoking; low body weight (<127 lb); estrogen deficiency caused by early (age <45 years) menopause, bilateral ovariectomy, or prolonged (>1 year) premenopausal amenorrhea; low lifelong calcium intake; alcoholism; impaired eyesight despite adequate correction; recurrent falls; inadequate physical activity. All women: certain diseases or medical conditions and those who take certain drugs associated with an increased risk of osteoporosis
Colorectal cancer screening**	Colorectal cancer or adenomatous polyps in first-degree relative younger than 60 years or in 2 or more first-degree relatives of any ages; family history of familial adenomatous polyposis or hereditary nonpolyposis colon cancer; history of colorectal cancer, adenomatous polyps, inflammatory bowel disease, chronic ulcerative colitis, or Crohn's disease
Fasting glucose testing	Overweight (body mass index ≥25 kg/m^2); family history of diabetes mellitus; habitual physical inactivity; high-risk race/ethnicity (eg, African American, Hispanic, Native American, Asian, Pacific Islander); have given birth to a newborn weighing more than 9 lb or history of gestational diabetes mellitus; hypertension; high-density lipoprotein cholesterol level ≤35 mg/dL; triglyceride level ≥250 mg/dL; history of impaired glucose tolerance or impaired fasting glucose; polycystic ovary syndrome; history of vascular disease
Genetic testing/counseling	Considering pregnancy and: will be 35 years or older at time of delivery; patient, partner, or family member with history of genetic disorder or birth defect; exposure to teratogens; or African, Acadian, European Caucasian, Eastern European (Ashkenazi) Jewish, Mediterranean, or Southeast Asian ancestry
Hemoglobin level assessment	Caribbean, Latin American, Asian, Mediterranean, or African ancestry; history of excessive menstrual flow
Hepatitis A virus (HAV) vaccination	Chronic liver disease; clotting factor disorders; illegal drug users; individuals who work with HAV-infected nonhuman primates or with HAV in a research laboratory setting; individuals traveling to or working in countries that have high or intermediate endemicity of hepatitis A
Hepatitis B virus (HBV) vaccination	Hemodialysis patients; patients who receive clotting factor concentrates; health care workers and public safety workers who have exposure to blood in the workplace; individuals in training in schools of medicine, dentistry, nursing, laboratory technology, and other allied health professions; injecting drug users; individuals with more than 1 sexual partner in the previous 6 months; individuals with a recently acquired sexually transmitted disease; all clients in sexually transmitted disease clinics; household contacts and sexual partners of individuals with chronic HBV infection; clients and staff of institutions for the developmentally disabled; international travelers who will be in countries with high or intermediate prevalence of chronic HBV infection for more than 6 months; inmates of correctional facilities
Hepatitis C virus (HCV) testing	History of injecting illegal drugs; recipients of clotting factor concentrates before 1987; chronic (long-term) hemodialysis; persistently abnormal alanine aminotransferase levels; recipient of blood from a donor who later tested positive for HCV infection; recipient of blood or blood-component transfusion or organ transplant before July 1992; occupational percutaneous or mucosal exposure to HCV-positive blood
Human immunodeficiency virus (HIV) testing	Seeking treatment for sexually transmitted diseases; drug use by injection; history of prostitution; past or present sexual partner who is HIV positive or bisexual or injects drugs; long-term residence or birth in an area with high prevalence of HIV infection; history of transfusion from 1978 to 1985; invasive cervical cancer. Offer to women seeking preconceptional evaluation.
Influenza vaccination	Anyone who wishes to reduce the chance of becoming ill with influenza; chronic cardiovascular or pulmonary disorders including asthma; chronic metabolic diseases, including diabetes mellitus, renal dysfunction, hemoglobinopathies, and immunosuppression (including immunosuppression caused by medications or by HIV); residents of nursing homes and other long-term care facilities; individuals likely to transmit influenza to high-risk individuals (eg, household members and caregivers of elderly, those with medical indications, and adults with high-risk conditions); health care workers; daycare workers
Lipid profile assessment	Family history suggestive of familial hyperlipidemia; family history of premature (age <50 years for men, age <60 years for women) cardiovascular disease; diabetes mellitus; multiple coronary heart disease risk factors (eg, tobacco use, hypertension)
Mammography	Women who have had breast cancer or who have a first-degree relative (ie, mother, sister, or daughter) or multiple other relatives who have a history of premenopausal breast or breast and ovarian cancer
Measles–mumps–rubella (MMR) vaccination	Adults born in 1957 or later should be offered vaccination (1 dose of measles–mumps–rubella vaccine) if there is no proof of immunity or documentation of a dose given after first birthday; individuals vaccinated in 1963–1967 should be offered revaccination (2 doses); health care workers, students entering college, international travelers, and rubella-negative postpartum patients should be offered a second dose.
Pneumococcal vaccination	Chronic illness, such as cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, chronic liver disease, cerebrospinal fluid leaks, functional asplenia (eg, sickle cell disease) or splenectomy; exposure to an environment where pneumococcal outbreaks have occurred; immunocompromised patients (eg, HIV infection, hematologic or solid malignancies, chemotherapy, steroid therapy). Revaccination after 5 years may be appropriate for certain high-risk groups.
Rubella titer assessment	Childbearing age and no evidence of immunity
Sexually transmitted disease (STD) testing	History of multiple sexual partners or a sexual partner with multiple contacts, sexual contact with individuals with culture-proven STD, history of repeated episodes of STDs, attendance at clinics for STDs; routine screening for chlamydial infection for all sexually active women aged 25 years or younger and other asymptomatic women at high risk for infection; routine screening for gonorrheal infection for all sexually active adolescents and other asymptomatic women at high risk for infection
Skin examination	Increased recreational or occupational exposure to sunlight; family or personal history of skin cancer; clinical evidence of precursor lesions
Thyroid stimulating hormone screening	Strong family history of thyroid disease; autoimmune disease (evidence of subclinical hypothyroidism may be related to unfavorable lipid profiles)
Tuberculosis skin testing	Human immunodeficiency virus infection; close contact with individuals known or suspected to have tuberculosis; medical risk factors known to increase risk of disease if infected; born in country with high tuberculosis prevalence; medically underserved; low income; alcoholism; intravenous drug use; resident of long-term care facility (eg, correctional institutions, mental institutions, nursing homes and facilities); health professional working in high-risk health care facilities
Varicella vaccination	All susceptible adults and adolescents, including health care workers; household contacts of immunocompromised individuals; teachers; daycare workers; residents and staff of institutional settings, colleges, prisons, or military installations; adolescents and adults living in households with children; international travelers; nonpregnant women of childbearing age

*For a more detailed discussion of bone density screening, see Osteoporosis, ACOG Practice Bulletin No. 50. American College of Obstetricians and Gynecologists. Obstet Gynecol 2004;103:203–16.

**For a more detailed discussion of colorectal cancer screening, see Smith RA, von Eschenbach AC, Wender R, Levin B, Byers T, Rothenberger D, et al. American Cancer Society guidelines for the early detection of cancer: update of early detection guidelines for prostate, colorectal, and endometrial cancers. Also: update 2001—testing for early lung cancer detection [published erratum appears in CA Cancer J Clin 2001;51:150]. CA Cancer J Clin 2001;51:38–75; quiz 77–80.

SAMPLE

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PATIENT NAME: ______________________________

BIRTH DATE: ______________________________

ID NO.: ______________________________

DATE: ______________________________

PHYSICIAN HISTORY

☐ NEW PATIENT	☐ ESTABLISHED PATIENT	☐ CONSULTATION	☐ REPORT SENT: / /
PRIMARY CARE PHYSICIAN:		WHO SENT PATIENT:	
OTHER PHYSICIAN(S):			
CHIEF COMPLAINT (CC) (REQUIRED FOR ALL VISITS EXCEPT PREVENTIVE):		CURRENT PRESCRIPTION MEDICATIONS: ☐ NONE	
HISTORY OF PRESENT ILLNESS (HPI):		CURRENT NONPRESCRIPTION, COMPLEMENTARY, AND ALTERNATIVE MEDICATIONS: ☐ NONE	

CHANGES SINCE LAST VISIT	**YES**	**NO**	**NOTES**
ILLNESSES	☐	☐	
SURGERY	☐	☐	
NEW MEDICATIONS	☐	☐	
CHANGE IN FAMILY HISTORY	☐	☐	
NEW ALLERGIES	☐	☐	
CHANGE IN GYNECOLOGIC HISTORY	☐	☐	
CHANGE IN OBSTETRIC HISTORY	☐	☐	

ALLERGIES (DESCRIBE REACTION): ☐ NONE

LAST CERVICAL CANCER SCREENING: ☐ CYTOLOGY / / ☐ HPV TEST / /

LAST MAMMOGRAM: / /

LAST COLORECTAL SCREENING: / /

SAMPLE

GYNECOLOGIC HISTORY (PH)

LMP: / / AGE AT MENARCHE: ________ LENGTH OF FLOW: ________ INTERVAL BETWEEN PERIODS: ________ RECENT CHANGES: ________

SEXUALLY ACTIVE ☐ YES ☐ NO EVER HAD SEX ☐ YES ☐ NO NUMBER OF PARTNERS (LIFETIME): ______

PARTNERS ARE: ☐ MEN ☐ WOMEN ☐ BOTH

CURRENT METHOD OF CONTRACEPTION: PAST CONTRACEPTIVE HISTORY:

OBSTETRIC HISTORY (PH)

	NUMBER		**NUMBER**		**NUMBER**
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	**BIRTH DATE**	**WEIGHT AT BIRTH**	**BABY'S SEX**	**WEEKS PREGNANT**	**TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)**	**PHYSICIAN'S NOTES**
1.						
2.						
3.						
4.						

ANY PREGNANCY COMPLICATIONS?

☐ DIABETES ☐ HYPERTENSION/HIGH BLOOD PRESSURE ☐ PREECLAMPSIA/TOXEMIA ☐ OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? ☐ NO ☐ YES, HOW TREATED

PAST HISTORY (PH)

☐ NONCONTRIBUTORY ☐ NO INTERVAL CHANGE SINCE: / /

SURGERIES:

ILLNESSES (PHYSICAL AND MENTAL):

INJURIES:

IMMUNIZATIONS/TUBERCULOSIS TEST:

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PHYSICIAN HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

FAMILY HISTORY (FH)

☐ NONCONTRIBUTORY ☐ NO INTERVAL CHANGE SINCE: / /

MOTHER: ☐ LIVING ☐ DECEASED–CAUSE: AGE: FATHER: ☐ LIVING ☐ DECEASED–CAUSE: AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

CHILDREN: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

(IF YES, INDICATE WHOM AND AGE AT DIAGNOSIS)

☐ DIABETES	☐ HEART DISEASE	☐ HYPERLIPIDEMIA
☐ CANCER	☐ HYPERTENSION	☐ DEEP VENOUS THROMBOEMBOLISM/PULMONARY EMBOLISM
☐ OSTEOPOROSIS	☐ OTHER ILLNESSES	

SOCIAL HISTORY (SH)

☐ NONCONTRIBUTORY ☐ NO INTERVAL CHANGE SINCE: / /

	YES	NO	NOTES		YES	NO	NOTES
TOBACCO USE	☐	☐		DIET DISCUSSED	☐	☐	
ALCOHOL USE–SPECIFY AMOUNT AND TYPE (12 OZ BEER = 5 OZ WINE = 1½ OZ LIQUOR)	☐	☐		FOLIC ACID INTAKE	☐	☐	
				CALCIUM INTAKE	☐	☐	
ILLEGAL/STREET DRUG USE	☐	☐		REGULAR EXERCISE	☐	☐	
MISUSE OF PRESCRIPTION DRUGS	☐	☐		CAFFEINE INTAKE	☐	☐	
INTIMATE PARTNER VIOLENCE	☐	☐		ADVANCE DIRECTIVE (LIVING WILL)	☐	☐	
SEXUAL ABUSE	☐	☐		ORGAN DONATION	☐	☐	
HEALTH HAZARDS AT HOME/WORK	☐	☐		OTHER			
SEAT BELT USE	☐	☐		☐ NO CHANGES SINCE: / /			

REVIEW OF SYSTEMS (ROS)

1. CONSTITUTIONAL	☐ NEGATIVE ☐ WEIGHT LOSS ☐ WEIGHT GAIN ☐ FEVER ☐ FATIGUE ☐ OTHER TALLEST HEIGHT_______________
2. EYES	☐ NEGATIVE ☐ VISION CHANGE ☐ GLASSES/CONTACTS ☐ OTHER
3. EAR, NOSE, AND THROAT	☐ NEGATIVE ☐ ULCERS ☐ SINUSITIS ☐ HEADACHE ☐ HEARING LOSS ☐ OTHER
4. CARDIOVASCULAR	☐ NEGATIVE ☐ ORTHOPNEA ☐ CHEST PAIN ☐ DIFFICULTY BREATHING ON EXERTION ☐ EDEMA ☐ PALPITATION ☐ OTHER
5. RESPIRATORY	☐ NEGATIVE ☐ WHEEZING ☐ HEMOPTYSIS ☐ SHORTNESS OF BREATH ☐ COUGH ☐ OTHER
6. GASTROINTESTINAL	☐ NEGATIVE ☐ DIARRHEA ☐ BLOODY STOOL ☐ NAUSEA/VOMITING/INDIGESTION ☐ CONSTIPATION ☐ FLATULENCE ☐ PAIN ☐ FECAL INCONTINENCE ☐ OTHER
7. GENITOURINARY	☐ NEGATIVE ☐ HEMATURIA ☐ DYSURIA ☐ URGENCY ☐ FREQUENCY ☐ INCOMPLETE EMPTYING ☐ INCONTINENCE ☐ DYSPAREUNIA ☐ ABNORMAL OR PAINFUL PERIODS ☐ PMS ☐ ABNORMAL VAGINAL BLEEDING ☐ ABNORMAL VAGINAL DISCHARGE ☐ OTHER
8. MUSCULOSKELETAL	☐ NEGATIVE ☐ MUSCLE WEAKNESS ☐ MUSCLE OR JOINT PAIN ☐ OTHER
9a. SKIN	☐ NEGATIVE ☐ RASH ☐ ULCERS ☐ DRY SKIN ☐ PIGMENTED LESIONS ☐ OTHER
9b. BREAST	☐ NEGATIVE ☐ MASTALGIA ☐ DISCHARGE ☐ MASSES ☐ OTHER
10. NEUROLOGIC	☐ NEGATIVE ☐ SYNCOPE ☐ SEIZURES ☐ NUMBNESS ☐ TROUBLE WALKING ☐ SEVERE MEMORY PROBLEMS ☐ OTHER
11. PSYCHIATRIC	☐ NEGATIVE ☐ DEPRESSION ☐ CRYING ☐ SEVERE ANXIETY ☐ OTHER
12. ENDOCRINE	☐ NEGATIVE ☐ DIABETES ☐ HYPOTHYROID ☐ HYPERTHYROID ☐ HOT FLASHES ☐ HAIR LOSS ☐ HEAT/COLD INTOLERANCE ☐ OTHER
13. HEMATOLOGIC/LYMPHATIC	☐ NEGATIVE ☐ BRUISES ☐ BLEEDING ☐ ADENOPATHY ☐ OTHER
14. ALLERGIC/IMMUNOLOGIC	(SEE FIRST PAGE)

SAMPLE

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PHYSICAL EXAMINATION

PATIENT NAME: | BIRTH DATE: / / | ID NO.: | DATE: / /

CONSTITUTIONAL

- VITAL SIGNS (RECORD ≥3 VITAL SIGNS):

HEIGHT: _________ WEIGHT: _________ BMI: _________ BLOOD PRESSURE (SITTING): _________ TEMPERATURE: _________ PULSE: _________ RESPIRATION: _________

- GENERAL APPEARANCE (NOTE ALL THAT APPLY):

☐ WELL-DEVELOPED ☐ OTHER ☐ NO DEFORMITIES ☐ OTHER

☐ WELL-NOURISHED ☐ OTHER ☐ WELL-GROOMED ☐ OTHER

☐ NORMAL HABITUS ☐ OBESE ☐ OTHER

NECK

- NECK ☐ NORMAL ☐ ABNORMAL ________
- THYROID ☐ NORMAL ☐ ABNORMAL ________

RESPIRATORY

- RESPIRATORY EFFORT ☐ NORMAL ☐ ABNORMAL ________
- AUSCULTATED LUNGS ☐ NORMAL ☐ ABNORMAL ________

CARDIOVASCULAR

- AUSCULTATED HEART
  - SOUNDS ☐ NORMAL ☐ ABNORMAL ________
  - MURMURS ☐ NORMAL ☐ ABNORMAL ________
- PERIPHERAL VASCULAR ☐ NORMAL ☐ ABNORMAL ________

GASTROINTESTINAL

- ABDOMEN ☐ NORMAL ☐ ABNORMAL ________
- HERNIA ☐ NONE ☐ PRESENT ________
- LIVER/SPLEEN
  - LIVER ☐ NORMAL ☐ ABNORMAL ________
  - SPLEEN ☐ NORMAL ☐ ABNORMAL ________
- STOOL GUAIAC, IF INDICATED ☐ POSITIVE ☐ NEGATIVE

LYMPHATIC

- PALPATION OF NODES (CHOOSE ALL THAT ARE APPLICABLE)
  - NECK ☐ NORMAL ☐ ABNORMAL ________
  - AXILLA ☐ NORMAL ☐ ABNORMAL ________
  - GROIN ☐ NORMAL ☐ ABNORMAL ________
  - OTHER SITE ☐ NORMAL ☐ ABNORMAL ________

SKIN

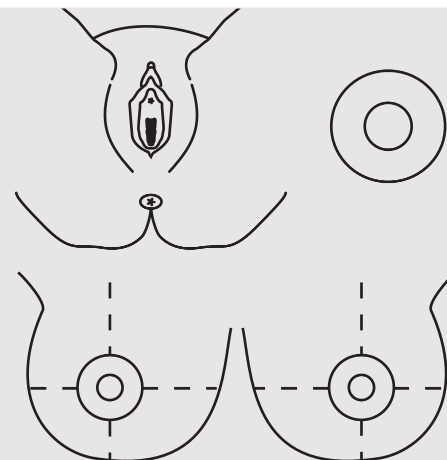
- INSPECTED/PALPATED ☐ NORMAL ☐ ABNORMAL

NEUROLOGIC/PSYCHIATRIC

- ORIENTATION ☐ TIME ☐ PLACE ☐ PERSON ☐ COMMENTS
- MOOD AND AFFECT ☐ NORMAL ☐ DEPRESSED ☐ ANXIOUS ☐ AGITATED ☐ OTHER

GYNECOLOGIC (AT LEAST 7)

- BREASTS ☐ NORMAL ☐ ABNORMAL ________
- EXTERNAL GENITALIA ☐ NORMAL ☐ ABNORMAL ________
- URETHRAL MEATUS ☐ NORMAL ☐ ABNORMAL ________
- URETHRA ☐ NORMAL ☐ ABNORMAL ________
- BLADDER ☐ NORMAL ☐ ABNORMAL ________
- VAGINA/PELVIC SUPPORT ☐ NORMAL ☐ ABNORMAL ________
- CERVIX ☐ NORMAL ☐ ABNORMAL ________
- UTERUS ☐ NORMAL ☐ ABNORMAL ________
- ADNEXA/PARAMETRIA ☐ NORMAL ☐ ABNORMAL ________
- ANUS/PERINEUM ☐ NORMAL ☐ ABNORMAL ________
- RECTAL ☐ NORMAL ☐ ABNORMAL ________



(SEE ALSO "STOOL GUAIAC" ABOVE)

- TOTAL NUMBER OF BULLETED (•) ELEMENTS EXAMINED:

SAMPLE

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MEDICAL DECISION MAKING

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

AMOUNT AND COMPLEXITY OF DATA REVIEWED

TEST(S) ORDERED:

☐ LABORATORY
- –CERVICAL CYTOLOGY
- –HPV TEST
- –WET MOUNT
- –CHLAMYDIA
- –GONORRHEA
- –OTHER:________________

☐ RADIOLOGY/ULTRASOUND
- –MAMMOGRAM
- –OTHER:________________

REVIEW OF RECORDS:

☐ PREVIOUS TEST RESULTS: ________________

☐ DISCUSSION OF TEST RESULTS WITH PERFORMING PHYSICIAN: ________________

☐ OLD RECORDS REVIEWED AND SUMMARIZED: ________________

☐ HISTORY OBTAINED FROM OTHER SOURCE: ________________

☐ INDEPENDENT REVIEW OF IMAGE/SPECIMEN: ________________

SAMPLE

DIAGNOSES/MANAGEMENT OPTIONS

☐ ESTABLISHED PROBLEM ☐ NEW PROBLEM

ASSESSMENT AND PLAN:

RISK OF COMPLICATIONS AND/OR MORBIDITY/MORTALITY:

☐ MINIMAL (EG, COLD, ACHES AND PAINS, OVER-THE-COUNTER MEDICATIONS)

☐ LOW (EG, CYSTITIS, VAGINITIS, PRESCRIPTION RENEWAL, MINOR SURGERY WITHOUT RISK FACTORS)

☐ MODERATE (EG, BREAST MASS, IRREGULAR BLEEDING, HEADACHES, MINOR SURGERY WITH RISK FACTORS, MAJOR SURGERY WITHOUT RISK FACTORS, NEW PRESCRIPTION)

☐ HIGH (EG, PELVIC PAIN, RECTAL BLEEDING, MULTIPLE COMPLAINTS, MAJOR SURGERY WITH RISK FACTORS, CHEMOTHERAPY, EMERGENCY SURGERY)

PATIENT COUNSELED ABOUT: ☐ SMOKING CESSATION ☐ CONTRACEPTION ☐ WEIGHT MANAGEMENT ☐ SAFE SEX ☐ EXERCISE ☐ OTHER

☐ **PATIENT EDUCATION MATERIALS PROVIDED**

MINUTES COUNSELED:	**TOTAL ENCOUNTER TIME:**
SIGNATURE:	**DATE: / /**

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FOR OFFICE USE ONLY
☐ NEW PATIENT
☐ ESTABLISHED PATIENT
☐ CONSULTATION
☐ REPORT SENT: / /

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /
ADDRESS:			
CITY:	STATE/ZIP:		
HOME TELEPHONE: ( )	WORK TELEPHONE: ( )		
EMPLOYER:	INSURANCE:	POLICY NO.:	
NAME YOU WOULD LIKE US TO USE:	PRIMARY LANGUAGE:		
NAME OF SPOUSE/PARTNER:	EMERGENCY CONTACT:		
	RELATIONSHIP:		
	HOME TELEPHONE: ( )	WORK TELEPHONE: ( )	
REFERRED BY:			
WHY HAVE YOU COME TO THE OFFICE TODAY?			
IF YOU ARE HERE FOR AN ANNUAL EXAMINATION IS THIS A ☐ PRIMARY CARE VISIT OR ☐ GYNECOLOGY ONLY			
IS THIS A NEW PROBLEM?			
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT HAS LASTED.			

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

GYNECOLOGIC HISTORY

	PHYSICIAN'S NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY): / /	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY RECENT CHANGES IN PERIODS?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD SEX?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
SEXUAL PARTNERS ARE ☐ MEN ☐ WOMEN ☐ BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST?	
WHAT WAS THE RESULT?	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO BREAST SELF-EXAMINATIONS?	
HAVE YOU BEEN EXPOSED TO DIETHYLSTILBESTROL (DES)?	

SAMPLE

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PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	PHYSICIAN'S NOTES
1.						
2.						
3.						
4.						

ANY PREGNANCY COMPLICATIONS?

☐ DIABETES ☐ HYPERTENSION/HIGH BLOOD PRESSURE ☐ PREECLAMPSIA/TOXEMIA ☐ OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? ☐ NO ☐ YES, HOW TREATED

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: ☐ LIVING ☐ DECEASED–CAUSE: AGE: FATHER: ☐ LIVING ☐ DECEASED–CAUSE: AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

CHILDREN: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	PHYSICIAN'S NOTES
DIABETES	☐		
STROKE	☐		
HEART DISEASE	☐		
BLOOD CLOTS IN LUNGS OR LEGS	☐		
HIGH BLOOD PRESSURE	☐		
HIGH CHOLESTEROL	☐		
OSTEOPOROSIS (WEAK BONES)	☐		
HEPATITIS	☐		
HIV/AIDS	☐		
TUBERCULOSIS	☐		
BIRTH DEFECTS	☐		
ALCOHOL OR DRUG PROBLEMS	☐		
BREAST CANCER	☐		
COLON CANCER	☐		
OVARIAN CANCER	☐		
UTERINE CANCER	☐		
MENTAL ILLNESS/DEPRESSION	☐		
ALZHEIMER'S DISEASE	☐		
OTHER	☐		

SAMPLE

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PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	☐	☐	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK: TYPE OF DRINK:	☐	☐	
DRUG USE	☐	☐	
SEAT BELT USE	☐	☐	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	☐	☐	
DAIRY PRODUCT INTAKE AND/OR CALCIUM SUPPLEMENTS: DAILY INTAKE:	☐	☐	
HEALTH HAZARDS AT HOME OR WORK?	☐	☐	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	☐	☐	
DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)?	☐	☐	
ARE YOU AN ORGAN DONOR?	☐	☐	

PERSONAL PROFILE

SEXUAL ORIENTATION: ☐ HETEROSEXUAL ☐ HOMOSEXUAL ☐ BISEXUAL

MARITAL STATUS: ☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

NUMBER OF LIVING CHILDREN:

NUMBER OF PEOPLE IN HOUSEHOLD:

SCHOOL COMPLETED: ☐ HIGH SCHOOL ☐ SOME COLLEGE/AA DEGREE ☐ COLLEGE ☐ GRADUATE DEGREE ☐ OTHER

CURRENT OR MOST RECENT JOB:

TRAVEL OUTSIDE THE UNITED STATES? LOCATION(S):

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
ASTHMA				
PNEUMONIA/LUNG DISEASE				
KIDNEY INFECTIONS/STONES				
TUBERCULOSIS				
FIBROIDS				
SEXUALLY TRANSMITTED DISEASE/CHLAMYDIA				
INFERTILITY				
HIV/AIDS				
HEART ATTACK/DISEASE				
DIABETES				
HIGH BLOOD PRESSURE				
STROKE				
RHEUMATIC FEVER				
BLOOD CLOTS IN LUNGS OR LEGS				
EATING DISORDERS				
AUTOIMMUNE DISEASE (LUPUS)				
CHICKENPOX				
CANCER				
REFLUX/HIATAL HERNIA/ULCERS				
DEPRESSION/ANXIETY				
ANEMIA				
BLOOD TRANSFUSIONS				
SEIZURES/CONVULSIONS/EPILEPSY				
BOWEL PROBLEMS				
GLAUCOMA				
CATARACTS				
ARTHRITIS/JOINT PAIN/BACK PROBLEMS				
BROKEN BONES				
HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE				
THYROID DISEASE				

SAMPLE

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PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

PERSONAL PAST HISTORY OF ILLNESSES *(Continued)*

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
GALLBLADDER DISEASE				
HEADACHES				
DES EXPOSURE				
INFERTILITY				
BLEEDING DISORDERS				
OTHER				

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

INJURIES/ILLNESSES

TYPE	DATE	TYPE	DATE

IMMUNIZATIONS/TEST

	DATE		DATE
TETANUS-DIPHTHERIA BOOSTER		INFLUENZA VACCINE (FLU SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA (CHICKENPOX) VACCINE		PNEUMOCOCCAL (PNEUMONIA) VACCINE	
MEASLES-MUMPS-RUBELLA (MMR) VACCINE		TUBERCULOSIS (TB) SKIN TEST: RESULT:	

PHYSICIAN'S NOTES:

REVIEW OF SYSTEMS

Please check (x) if any of the following symptoms apply to you now or since adulthood

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
1. CONSTITUTIONAL				
WEIGHT LOSS	☐	☐	☐	
WEIGHT GAIN	☐	☐	☐	
FEVER	☐	☐	☐	
FATIGUE	☐	☐	☐	
CHANGE IN HEIGHT	☐	☐	☐	

SAMPLE

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PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

REVIEW OF SYSTEMS *(Continued)*

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
2. EYES				
DOUBLE VISION	☐	☐	☐	
SPOTS BEFORE EYES	☐	☐	☐	
VISION CHANGES	☐	☐	☐	
GLASSES/CONTACTS	☐	☐	☐	
3. EAR, NOSE, AND THROAT				
EARACHES	☐	☐	☐	
RINGING IN EARS	☐	☐	☐	
HEARING PROBLEMS	☐	☐	☐	
SINUS PROBLEMS	☐	☐	☐	
SORE THROAT	☐	☐	☐	
MOUTH SORES	☐	☐	☐	
DENTAL PROBLEMS	☐	☐	☐	
4. CARDIOVASCULAR				
CHEST PAIN OR PRESSURE	☐	☐	☐	
DIFFICULTY BREATHING ON EXERTION	☐	☐	☐	
SWELLING OF LEGS	☐	☐	☐	
RAPID OR IRREGULAR HEARTBEAT	☐	☐	☐	
5. RESPIRATORY				
PAINFUL BREATHING	☐	☐	☐	
WHEEZING	☐	☐	☐	
SPITTING UP BLOOD	☐	☐	☐	
SHORTNESS OF BREATH	☐	☐	☐	
CHRONIC COUGH	☐	☐	☐	
6. GASTROINTESTINAL				
FREQUENT DIARRHEA	☐	☐	☐	
BLOODY STOOL	☐	☐	☐	
NAUSEA/VOMITING/INDIGESTION	☐	☐	☐	
CONSTIPATION	☐	☐	☐	
INVOLUNTARY LOSS OF GAS OR STOOL	☐	☐	☐	
7. GENITOURINARY				
BLOOD IN URINE	☐	☐	☐	
PAIN WITH URINATION	☐	☐	☐	
STRONG URGENCY TO URINATE	☐	☐	☐	
FREQUENT URINATION	☐	☐	☐	
INCOMPLETE EMPTYING	☐	☐	☐	
INVOLUNTARY/UNINTENDED URINE LOSS	☐	☐	☐	
URINE LOSS WHEN COUGHING OR LIFTING	☐	☐	☐	
ABNORMAL BLEEDING	☐	☐	☐	
PAINFUL PERIODS	☐	☐	☐	
PREMENSTRUAL SYNDROME (PMS)	☐	☐	☐	
PAINFUL INTERCOURSE	☐	☐	☐	
ABNORMAL VAGINAL DISCHARGE	☐	☐	☐	
8. MUSCULOSKELETAL				
MUSCLE WEAKNESS	☐	☐	☐	

SAMPLE

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PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

REVIEW OF SYSTEMS *(Continued)*

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
8. MUSCULOSKELETAL *(Continued)*				
MUSCLE OR JOINT PAIN	☐	☐	☐	
9a. SKIN				
RASH	☐	☐	☐	
SORES	☐	☐	☐	
DRY SKIN	☐	☐	☐	
MOLES (GROWTH OR CHANGES)	☐	☐	☐	
9b. BREASTS				
PAIN IN BREAST	☐	☐	☐	
NIPPLE DISCHARGE	☐	☐	☐	
LUMPS	☐	☐	☐	
10. NEUROLOGIC				
DIZZINESS	☐	☐	☐	
SEIZURES	☐	☐	☐	
NUMBNESS	☐	☐	☐	
TROUBLE WALKING	☐	☐	☐	
MEMORY PROBLEMS	☐	☐	☐	
FREQUENT HEADACHES	☐	☐	☐	
11. PSYCHIATRIC				
DEPRESSION OR FREQUENT CRYING	☐	☐	☐	
ANXIETY	☐	☐	☐	
12. ENDOCRINE				
HAIR LOSS	☐	☐	☐	
HEAT/COLD INTOLERANCE	☐	☐	☐	
ABNORMAL THIRST	☐	☐	☐	
HOT FLASHES	☐	☐	☐	
13. HEMATOLOGIC/LYMPHATIC				
FREQUENT BRUISES	☐	☐	☐	
CUTS DO NOT STOP BLEEDING	☐	☐	☐	
ENLARGED LYMPH NODES (GLANDS)	☐	☐	☐	
14. ALLERGIC/IMMUNOLOGIC				
MEDICATION ALLERGIES	☐	☐	☐	
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:				
LATEX ALLERGY	☐	☐	☐	
OTHER ALLERGIES	☐	☐	☐	
PLEASE LIST ALLERGY AND TYPE OF REACTION:				

FORM COMPLETED BY: ☐ PATIENT ☐ OFFICE NURSE ☐ PHYSICIAN ☐ OTHER:

SIGNATURE OF PATIENT:

DATE REVIEWED BY PHYSICIAN WITH PATIENT: / /	PHYSICIAN SIGNATURE:

ANNUAL REVIEW OF HISTORY

DATE REVIEWED: / /	PHYSICIAN SIGNATURE:
DATE REVIEWED: / /	PHYSICIAN SIGNATURE:
DATE REVIEWED: / /	PHYSICIAN SIGNATURE:
DATE REVIEWED: / /	PHYSICIAN SIGNATURE:
DATE REVIEWED: / /	PHYSICIAN SIGNATURE:

SAMPLE

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ACOG WOMAN'S HEALTH RECORD

CODING TIPS*

HISTORY

CHIEF COMPLAINT (CC)

REQUIRED FOR ALL VISITS EXCEPT PREVENTIVE VISITS

HISTORY OF PRESENT ILLNESS (HPI)

BRIEF = 1–3 ELEMENTS EXTENDED = 4+ ELEMENTS OR STATUS OF 3+ CHRONIC/INACTIVE CONDITIONS

FACTORS TO BE CONSIDERED INCLUDE:

LOCATION, QUALITY, SEVERITY, DURATION, TIMING, CONTEXT, MODIFYING FACTORS, ASSOCIATED SIGNS AND SYMPTOMS

PAST, FAMILY, AND SOCIAL HISTORY (PFSH)

PERTINENT PFSH = 1 SPECIFIC ITEM FROM EITHER PAST, FAMILY, OR SOCIAL HISTORY

COMPLETE PFSH = NEW PATIENT: 1 SPECIFIC ITEM FROM EACH HISTORY TYPE (PAST, FAMILY, OR SOCIAL HISTORY)

ESTABLISHED PATIENT: 1 SPECIFIC ITEM FROM 2 OF THE 3 HISTORY TYPES (PAST, FAMILY, OR SOCIAL HISTORY)

REVIEW OF SYSTEMS (ROS)

PROBLEM PERTINENT ROS = POSITIVE AND PERTINENT NEGATIVE RESPONSES RELATED TO PROBLEM

EXTENDED ROS = POSITIVE AND PERTINENT NEGATIVE RESPONSES FOR 2–9 SYSTEMS

COMPLETE ROS = POSITIVE AND PERTINENT NEGATIVE RESPONSES FOR AT LEAST 10 SYSTEMS

LEVEL OF HISTORY

(All three elements must be met for a given level of history, eg, brief HPI, problem pertinent ROS, and pertinent PFSH is an Expanded Problem Focused history)

CC	HPI	ROS	PFSH	LEVEL OF HISTORY
REQUIRED	BRIEF (1–3 ELEMENTS)	NONE REQUIRED	NONE REQUIRED	PROBLEM FOCUSED
REQUIRED	BRIEF (1–3 ELEMENTS)	PROBLEM PERTINENT	NONE REQUIRED	EXPANDED PROBLEM FOCUSED
REQUIRED	EXTENDED (4+ ELEMENTS OR STATUS OF 3+ CHRONIC/INACTIVE CONDITIONS)	EXTENDED (2–9 SYSTEMS)	PERTINENT (1 OF 3)	DETAILED
REQUIRED	EXTENDED (4+ ELEMENTS OR STATUS OF 3+ CHRONIC/INACTIVE CONDITIONS)	COMPLETE (10+ SYSTEMS)	COMPLETE (NEW PATIENT: 3 OF 3; ESTABLISHED PATIENT: 2 OF 3)	COMPREHENSIVE

PHYSICAL EXAMINATION

1997 CMS Guidelines, Female Genitourinary System Examination

The female genitourinary examination template includes 9 organ systems/body areas with 3 shaded boxes and 6 unshaded boxes. The shading only becomes important when a comprehensive examination is performed. For all other levels of examination, the total number of bulleted elements documented in the medical record will determine the level that can be reported.

LEVEL OF EXAMINATION	PERFORM AND DOCUMENT
PROBLEM FOCUSED	1-5 ELEMENTS IDENTIFIED BY A BULLET
EXPANDED PROBLEM FOCUSED	6–11 ELEMENTS IDENTIFIED BY A BULLET
DETAILED	12 OR MORE ELEMENTS IDENTIFIED BY A BULLET
COMPREHENSIVE	ALL ELEMENTS IDENTIFIED BY A BULLET IN CONSTITUTIONAL AND GASTROINTESTINAL, ANY 7 BULLETS IN GYNECOLOGIC, AT LEAST 1 BULLET IN ALL OTHER SYSTEMS

MEDICAL DECISION MAKING

AMOUNT AND COMPLEXITY OF DATA REVIEWED

MINIMAL/NONE = 1 BOX LIMITED = 2 BOXES MODERATE = 3 BOXES EXTENSIVE = 4+ BOXES

THE FOLLOWING ITEMS (IF CHECKED) COUNT AS 2 BOXES:

- OLD RECORDS REVIEWED AND SUMMARIZED
- HISTORY OBTAINED FROM OTHER SOURCE
- INDEPENDENT REVIEW OF IMAGE/SPECIMEN

SAMPLE

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CODING TIPS* *(Continued)*

MEDICAL DECISION MAKING *(Continued)*

DIAGNOSES/MANAGEMENT OPTIONS

MINIMAL = MINOR PROBLEM; ESTABLISHED PROBLEM, STABLE/IMPROVED

LIMITED = ESTABLISHED PROBLEM, WORSENING

MULTIPLE = NEW PROBLEM, NO ADDITIONAL WORKUP PLANNED

EXTENSIVE = NEW PROBLEM, ADDITIONAL WORKUP PLANNED

RISK OF COMPLICATIONS AND/OR MORBIDITY/MORTALITY FROM DIAGNOSES, DIAGNOSTIC PROCEDURES, AND MANAGEMENT CHOICES:

MINIMAL (EG, COLD, ACHES AND PAINS, OVER-THE-COUNTER MEDICATIONS)

LOW (EG, CYSTITIS, VAGINITIS, PRESCRIPTION RENEWAL, MINOR SURGERY WITHOUT RISK FACTORS)

MODERATE (EG, BREAST MASS, IRREGULAR BLEEDING, HEADACHES, BIOPSY, MINOR SURGERY WITH RISK FACTORS, MAJOR SURGERY WITHOUT RISK FACTORS, NEW PRESCRIPTION)

HIGH (EG, PELVIC PAIN, RECTAL BLEEDING, MULTIPLE COMPLAINTS, MAJOR SURGERY WITH RISK FACTORS, CHEMOTHERAPY, EMERGENCY SURGERY)

2 of the 3 elements must be met or exceeded to qualify for a given type of medical decision making

AMOUNT/COMPLEXITY OF DATA	DIAGNOSES/MANAGEMENT OPTIONS	RISK OF COMPLICATIONS	TYPE OF DECISION MAKING
MINIMAL/NONE	MINIMAL	MINIMAL	STRAIGHTFORWARD
LIMITED	LIMITED	LOW	LOW COMPLEXITY
MODERATE	MULTIPLE	MODERATE	MODERATE COMPLEXITY
EXTENSIVE	EXTENSIVE	HIGH	HIGH COMPLEXITY

CODING SUMMARY

Office or Other Outpatient Services, New Patient

KEY COMPONENTS	99201	99202	99203	99204	99205
HISTORY	PROBLEM FOCUSED	EXPANDED PROBLEM FOCUSED	DETAILED	COMPREHENSIVE	COMPREHENSIVE
EXAMINATION	PROBLEM FOCUSED	EXPANDED PROBLEM FOCUSED	DETAILED	COMPREHENSIVE	COMPREHENSIVE
MEDICAL DECISION MAKING	STRAIGHTFORWARD	STRAIGHTFORWARD	LOW COMPLEXITY	MODERATE COMPLEXITY	HIGH COMPLEXITY
NO. OF KEY COMPONENTS REQUIRED	ALL 3	ALL 3	ALL 3	ALL 3	ALL 3
TYPICAL FACE-TO-FACE TIME (MIN)	10	20	30	45	60

Office or Other Outpatient Services, Established Patient

KEY COMPONENTS	99211	99212	99213	99214	99215
HISTORY	NOT REQUIRED	PROBLEM FOCUSED	EXPANDED PROBLEM FOCUSED	DETAILED	COMPREHENSIVE
EXAMINATION	NOT REQUIRED	PROBLEM FOCUSED	EXPANDED PROBLEM FOCUSED	DETAILED	COMPREHENSIVE
MEDICAL DECISION MAKING	NOT REQUIRED	STRAIGHTFORWARD	LOW COMPLEXITY	MODERATE COMPLEXITY	HIGH COMPLEXITY
NO. OF KEY COMPONENTS REQUIRED	NOT REQUIRED	2 OF 3	2 OF 3	2 OF 3	2 OF 3
TYPICAL FACE-TO-FACE TIME (MIN)	5	10	15	25	40

Office or Other Outpatient Consultations, New or Established Patient

KEY COMPONENTS	99241	99242	99243	99244	99245
HISTORY	PROBLEM FOCUSED	EXPANDED PROBLEM FOCUSED	DETAILED	COMPREHENSIVE	COMPREHENSIVE
EXAMINATION	PROBLEM FOCUSED	EXPANDED PROBLEM FOCUSED	DETAILED	COMPREHENSIVE	COMPREHENSIVE
MEDICAL DECISION MAKING	STRAIGHTFORWARD	STRAIGHTFORWARD	LOW COMPLEXITY	MODERATE COMPLEXITY	HIGH COMPLEXITY
NO. OF KEY COMPONENTS REQUIRED	ALL 3	ALL 3	ALL 3	ALL 3	ALL 3
TYPICAL FACE-TO-FACE TIME (MIN)	15	30	40	60	80

SAMPLE

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PATIENT NAME: ____________________

BIRTH DATE: ____________________

ID NO.: ____________________

DATE: ____________________

PROBLEM LIST

HIGH RISK:	FAMILY HISTORY:
DRUG/LATEX/TRANSFUSION/ALLERGIC REACTIONS:	**CURRENT MEDICATIONS:**

NO.	ENTRY DATE	PROBLEM/RESOLUTION	ONSET AGE AND DATE	RESOLUTION DATE
1				
2				
3				
4				
5				
6				
7				
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23				
24				
25				

SAMPLE

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IMMUNIZATION RECORD*

SAMPLE

PATIENT NAME: BIRTH DATE: / / ID NO.:

AGE	TETANUS–DIPHTHERIA BOOSTER	INFLUENZA VACCINE	PNEUMOCOCCAL VACCINE	MMR VACCINE	HEPATITIS B VACCINE	HEPATITIS A VACCINE	VARICELLA VACCINE
13-18	ONCE BETWEEN AGES 11-16	BASED ON RISK	BASED ON RISK	BASED ON RISK	ONE SERIES FOR THOSE NOT PREVIOUSLY IMMUNIZED	BASED ON RISK	BASED ON RISK
19-39	EVERY 10 YEARS	BASED ON RISK	BASED ON RISK	BASED ON RISK	BASED ON RISK	BASED ON RISK	BASED ON RISK
40-64	EVERY 10 YEARS	ANNUALLY BEGINNING AT AGE 50 YEARS	BASED ON RISK	BASED ON RISK	BASED ON RISK	BASED ON RISK	BASED ON RISK
65 AND OLDER	EVERY 10 YEARS	ANNUALLY	ONCE		BASED ON RISK	BASED ON RISK	BASED ON RISK

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*For immunizations based on risk refer to the Table of High-Risk Factors.

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ROUTINE SCREENING RECORD

PATIENT NAME: BIRTH DATE: / / ID NO.:

AGE	CERVICAL CYTOLOGY	LIPID PROFILE ASSESSMENT*	MAMMOGRAPHY*	COLORECTAL CANCER SCREENING*	BONE DENSITY SCREENING*	CHLAMYDIA SCREENING*	GONORRHEA SCREENING*	URINALYSIS	FASTING GLUCOSE TEST*	THYROID STIMULATING HORMONE SCREENING
13-18	ANNUALLY BEGINNING APPROXIMATELY 3 YEARS AFTER INITIATION OF SEXUAL INTERCOURSE					SEXUALLY ACTIVE WOMEN UNDER AGE 25	SEXUALLY ACTIVE ADOLESCENTS			
19-39	ANNUALLY BEGINNING NO LATER THAN AGE 21 YEARS					SEXUALLY ACTIVE WOMEN UNDER AGE 25				
40-64	EVERY 2-3 YEARS AFTER 3 CONSECUTIVE NEGATIVE TEST RESULTS IF NO HISTORY OF CIN 2 OR 3, IMMUNOSUPPRESSION, HIV INFECTION, OR DES EXPOSURE IN UTERO	EVERY 5 YEARS BEGINNING AT AGE 45	EVERY 1-2 YEARS UNTIL AGE 50; YEARLY BEGINNING AT AGE 50	BEGINNING AT AGE 50 YEARLY FOBT OR FLEXIBLE SIGMOIDOSCOPY EVERY 5 YEARS OR YEARLY FOBT PLUS FLEXIBLE SIGMOIDOSCOPY EVERY 5 YEARS OR DCBE EVERY 5 YEARS OR COLONOSCOPY EVERY 10 YEARS					EVERY 3 YEARS AFTER AGE 45	EVERY 5 YEARS BEGINNING AT AGE 50
65 AND OLDER	EVERY 2-3 YEARS AFTER 3 CONSECUTIVE NEGATIVE TEST RESULTS IF NO HISTORY OF CIN 2 OR 3, IMMUNOSUPPRESSION, HIV INFECTION, OR DES EXPOSURE IN UTERO	EVERY 5 YEARS	YEARLY OR AS APPROPRIATE	YEARLY FOBT OR FLEXIBLE SIGMOIDOSCOPY EVERY 5 YEARS OR YEARLY FOBT PLUS FLEXIBLE SIGMOIDOSCOPY EVERY 5 YEARS OR DCBE EVERY 5 YEARS OR COLONOSCOPY EVERY 10 YEARS	IN THE ABSENCE OF NEW RISK FACTORS, SUBSEQUENT SCREENING NOT MORE FREQUENTLY THAN EVERY 2 YEARS			YEARLY OR AS APPROPRIATE	EVERY 3 YEARS	EVERY 5 YEARS

DATE: RESULT:										
DATE: RESULT:										
DATE: RESULT:										
DATE: RESULT:										
DATE: RESULT:										
DATE: RESULT:										
DATE: RESULT:										
DATE: RESULT										

*This test may be appropriate for other patients based on risk (see High-Risk Laboratory Record and Table of High-Risk Factors)

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SAMPLE

HIGH-RISK SCREENING RECORD*

PATIENT NAME: | BIRTH DATE: / / | ID NO.:

	HEMOGLOBIN TEST	BONE DENSITY SCREENING	BACTERIURIA TEST	STD TESTING	HIV TEST**	GENETIC TESTING	RUBELLA TITER	TB SKIN TEST	LIPID PROFILE ASSESSMENT	MAMMOGRAPHY	FASTING GLUCOSE TEST	TSH TEST	COLORECTAL CANCER SCREENING	HEPATITIS C VIRUS TEST
DATE: RESULT:														
DATE: RESULT:														
DATE: RESULT:														
DATE: RESULT:														
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*See Table of High-Risk Factors.
**Check state requirements before recording results.

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SAMPLE

Patient Addressograph

PATIENT NAME: ______________________

BIRTH DATE: ______________________

ID NO.: ______________________

DATE: ______________________

PHYSICIAN HISTORY– ADDITIONAL VISIT FORM

☐ NEW PATIENT	☐ ESTABLISHED PATIENT	☐ CONSULTATION	☐ REPORT SENT: / /
PRIMARY CARE PHYSICIAN:		WHO SENT PATIENT:	
OTHER PHYSICIAN(S):			
CHIEF COMPLAINT (CC) (REQUIRED FOR ALL VISITS EXCEPT PREVENTIVE):		CURRENT PRESCRIPTION MEDICATIONS: ☐ NONE	
HISTORY OF PRESENT ILLNESS (HPI):		CURRENT NONPRESCRIPTION, COMPLEMENTARY, AND ALTERNATIVE MEDICATIONS: ☐ NONE	

CHANGES SINCE LAST VISIT	**YES**	**NO**	**NOTES**
ILLNESSES	☐	☐	
SURGERY	☐	☐	
NEW MEDICATIONS	☐	☐	
CHANGE IN FAMILY HISTORY	☐	☐	
NEW ALLERGIES	☐	☐	
CHANGE IN GYNECOLOGIC HISTORY	☐	☐	
CHANGE IN OBSTETRIC HISTORY	☐	☐	

ALLERGIES (DESCRIBE REACTION): ☐ NONE	
LAST CERVICAL CANCER SCREENING: ☐ CYTOLOGY / / ☐ HPV TEST / /	
LAST MAMMOGRAM: / /	
LAST COLORECTAL SCREENING: / /	

SAMPLE

GYNECOLOGIC HISTORY (PH)

LMP: / /	AGE AT MENARCHE: ________	LENGTH OF FLOW: ________	INTERVAL BETWEEN PERIODS: ________	RECENT CHANGES: ________
SEXUALLY ACTIVE ☐ YES ☐ NO	EVER HAD SEX ☐ YES ☐ NO	NUMBER OF PARTNERS (LIFETIME): ______		
PARTNERS ARE: ☐ MEN ☐ WOMEN ☐ BOTH				
CURRENT METHOD OF CONTRACEPTION:		PAST CONTRACEPTIVE HISTORY:		

OBSTETRIC HISTORY (PH)

	NUMBER		**NUMBER**		**NUMBER**
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	**BIRTH DATE**	**WEIGHT AT BIRTH**	**BABY'S SEX**	**WEEKS PREGNANT**	**TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)**	**PHYSICIAN'S NOTES**
1.						
2.						
3.						
4.						

ANY PREGNANCY COMPLICATIONS?

☐ DIABETES ☐ HYPERTENSION/HIGH BLOOD PRESSURE ☐ PREECLAMPSIA/TOXEMIA ☐ OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? ☐ NO ☐ YES, HOW TREATED

PAST HISTORY (PH)

☐ NONCONTRIBUTORY ☐ NO INTERVAL CHANGE SINCE: / /
SURGERIES:
ILLNESSES (PHYSICAL AND MENTAL):
INJURIES:
IMMUNIZATIONS/TUBERCULOSIS TEST:

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PHYSICIAN HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

FAMILY HISTORY (FH)

☐ NONCONTRIBUTORY ☐ NO INTERVAL CHANGE SINCE: / /

MOTHER: ☐ LIVING ☐ DECEASED–CAUSE: AGE: FATHER: ☐ LIVING ☐ DECEASED–CAUSE: AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

CHILDREN: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

(IF YES, INDICATE WHOM AND AGE AT DIAGNOSIS)

☐ DIABETES	☐ HEART DISEASE	☐ HYPERLIPIDEMIA
☐ CANCER	☐ HYPERTENSION	☐ DEEP VENOUS THROMBOEMBOLISM/PULMONARY EMBOLISM
☐ OSTEOPOROSIS	☐ OTHER ILLNESSES	

SOCIAL HISTORY (SH)

☐ NONCONTRIBUTORY ☐ NO INTERVAL CHANGE SINCE: / /

	YES	NO	NOTES		YES	NO	NOTES
TOBACCO USE	☐	☐		DIET DISCUSSED	☐	☐	
ALCOHOL USE–SPECIFY AMOUNT AND TYPE (12 OZ BEER = 5 OZ WINE = 1½ OZ LIQUOR)	☐	☐		FOLIC ACID INTAKE	☐	☐	
				CALCIUM INTAKE	☐	☐	
ILLEGAL/STREET DRUG USE	☐	☐		REGULAR EXERCISE	☐	☐	
MISUSE OF PRESCRIPTION DRUGS	☐	☐		CAFFEINE INTAKE	☐	☐	
INTIMATE PARTNER VIOLENCE	☐	☐		ADVANCE DIRECTIVE (LIVING WILL)	☐	☐	
SEXUAL ABUSE	☐	☐		ORGAN DONATION	☐	☐	
HEALTH HAZARDS AT HOME/WORK	☐	☐		OTHER			
SEAT BELT USE	☐	☐		☐ NO CHANGES SINCE: / /			

REVIEW OF SYSTEMS (ROS)

1. CONSTITUTIONAL	☐ NEGATIVE ☐ WEIGHT LOSS ☐ WEIGHT GAIN ☐ FEVER ☐ FATIGUE ☐ OTHER TALLEST HEIGHT________________
2. EYES	☐ NEGATIVE ☐ VISION CHANGE ☐ GLASSES/CONTACTS ☐ OTHER
3. EAR, NOSE, AND THROAT	☐ NEGATIVE ☐ ULCERS ☐ SINUSITIS ☐ HEADACHE ☐ HEARING LOSS ☐ OTHER
4. CARDIOVASCULAR	☐ NEGATIVE ☐ ORTHOPNEA ☐ CHEST PAIN ☐ DIFFICULTY BREATHING ON EXERTION ☐ EDEMA ☐ PALPITATION ☐ OTHER
5. RESPIRATORY	☐ NEGATIVE ☐ WHEEZING ☐ HEMOPTYSIS ☐ SHORTNESS OF BREATH ☐ COUGH ☐ OTHER
6. GASTROINTESTINAL	☐ NEGATIVE ☐ DIARRHEA ☐ BLOODY STOOL ☐ NAUSEA/VOMITING/INDIGESTION ☐ CONSTIPATION ☐ FLATULENCE ☐ PAIN ☐ FECAL INCONTINENCE ☐ OTHER
7. GENITOURINARY	☐ NEGATIVE ☐ HEMATURIA ☐ DYSURIA ☐ URGENCY ☐ FREQUENCY ☐ INCOMPLETE EMPTYING ☐ INCONTINENCE ☐ DYSPAREUNIA ☐ ABNORMAL OR PAINFUL PERIODS ☐ PMS ☐ ABNORMAL VAGINAL BLEEDING ☐ ABNORMAL VAGINAL DISCHARGE ☐ OTHER
8. MUSCULOSKELETAL	☐ NEGATIVE ☐ MUSCLE WEAKNESS ☐ MUSCLE OR JOINT PAIN ☐ OTHER
9a. SKIN	☐ NEGATIVE ☐ RASH ☐ ULCERS ☐ DRY SKIN ☐ PIGMENTED LESIONS ☐ OTHER
9b. BREAST	☐ NEGATIVE ☐ MASTALGIA ☐ DISCHARGE ☐ MASSES ☐ OTHER
10. NEUROLOGIC	☐ NEGATIVE ☐ SYNCOPE ☐ SEIZURES ☐ NUMBNESS ☐ TROUBLE WALKING ☐ SEVERE MEMORY PROBLEMS ☐ OTHER
11. PSYCHIATRIC	☐ NEGATIVE ☐ DEPRESSION ☐ CRYING ☐ SEVERE ANXIETY ☐ OTHER
12. ENDOCRINE	☐ NEGATIVE ☐ DIABETES ☐ HYPOTHYROID ☐ HYPERTHYROID ☐ HOT FLASHES ☐ HAIR LOSS ☐ HEAT/COLD INTOLERANCE ☐ OTHER
13. HEMATOLOGIC/LYMPHATIC	☐ NEGATIVE ☐ BRUISES ☐ BLEEDING ☐ ADENOPATHY ☐ OTHER
14. ALLERGIC/IMMUNOLOGIC	(SEE FIRST PAGE)

SAMPLE

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PHYSICAL EXAMINATION

PATIENT NAME: | BIRTH DATE: / / | ID NO.: | DATE: / /

CONSTITUTIONAL

• VITAL SIGNS (RECORD ≥3 VITAL SIGNS):

HEIGHT: _________ WEIGHT: _________ BMI: _________ BLOOD PRESSURE (SITTING): _________ TEMPERATURE: _________ PULSE: _________ RESPIRATION: _________

• GENERAL APPEARANCE (NOTE ALL THAT APPLY):

☐ WELL-DEVELOPED ☐ OTHER ☐ NO DEFORMITIES ☐ OTHER
☐ WELL-NOURISHED ☐ OTHER ☐ WELL-GROOMED ☐ OTHER
☐ NORMAL HABITUS ☐ OBESE ☐ OTHER

NECK

• NECK ☐ NORMAL ☐ ABNORMAL ____________
• THYROID ☐ NORMAL ☐ ABNORMAL ____________

RESPIRATORY

• RESPIRATORY EFFORT ☐ NORMAL ☐ ABNORMAL ____________
• AUSCULTATED LUNGS ☐ NORMAL ☐ ABNORMAL ____________

CARDIOVASCULAR

• AUSCULTATED HEART
SOUNDS ☐ NORMAL ☐ ABNORMAL ____________
MURMURS ☐ NORMAL ☐ ABNORMAL ____________
• PERIPHERAL VASCULAR ☐ NORMAL ☐ ABNORMAL ____________

GASTROINTESTINAL

• ABDOMEN ☐ NORMAL ☐ ABNORMAL ____________
• HERNIA ☐ NONE ☐ PRESENT ____________
• LIVER/SPLEEN
LIVER ☐ NORMAL ☐ ABNORMAL ____________
SPLEEN ☐ NORMAL ☐ ABNORMAL ____________
• STOOL GUAIAC, IF INDICATED ☐ POSITIVE ☐ NEGATIVE

LYMPHATIC

• PALPATION OF NODES (CHOOSE ALL THAT ARE APPLICABLE)
NECK ☐ NORMAL ☐ ABNORMAL ____________
AXILLA ☐ NORMAL ☐ ABNORMAL ____________
GROIN ☐ NORMAL ☐ ABNORMAL ____________
OTHER SITE ☐ NORMAL ☐ ABNORMAL ____________

SKIN

• INSPECTED/PALPATED ☐ NORMAL ☐ ABNORMAL

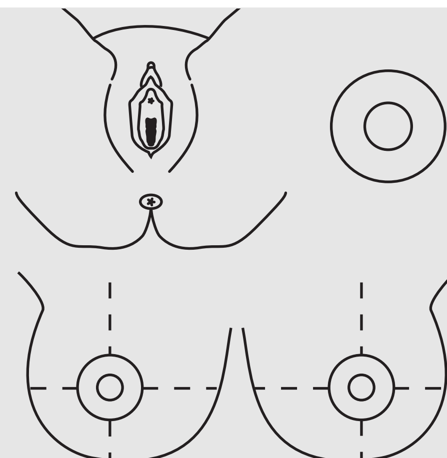
NEUROLOGIC/PSYCHIATRIC

• ORIENTATION ☐ TIME ☐ PLACE ☐ PERSON ☐ COMMENTS
• MOOD AND AFFECT ☐ NORMAL ☐ DEPRESSED ☐ ANXIOUS ☐ AGITATED ☐ OTHER

GYNECOLOGIC (AT LEAST 7)

• BREASTS ☐ NORMAL ☐ ABNORMAL ____________
• EXTERNAL GENITALIA ☐ NORMAL ☐ ABNORMAL ____________
• URETHRAL MEATUS ☐ NORMAL ☐ ABNORMAL ____________
• URETHRA ☐ NORMAL ☐ ABNORMAL ____________
• BLADDER ☐ NORMAL ☐ ABNORMAL ____________
• VAGINA/PELVIC SUPPORT ☐ NORMAL ☐ ABNORMAL ____________
• CERVIX ☐ NORMAL ☐ ABNORMAL ____________
• UTERUS ☐ NORMAL ☐ ABNORMAL ____________
• ADNEXA/PARAMETRIA ☐ NORMAL ☐ ABNORMAL ____________
• ANUS/PERINEUM ☐ NORMAL ☐ ABNORMAL ____________
• RECTAL ☐ NORMAL ☐ ABNORMAL ____________

(SEE ALSO "STOOL GUAIAC" ABOVE)



• TOTAL NUMBER OF BULLETED (•) ELEMENTS EXAMINED:

SAMPLE

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MEDICAL DECISION MAKING

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

AMOUNT AND COMPLEXITY OF DATA REVIEWED

TEST(S) ORDERED:

☐ LABORATORY
- –CERVICAL CYTOLOGY
- –HPV TEST
- –WET MOUNT
- –CHLAMYDIA
- –GONORRHEA
- –OTHER:________________________

☐ RADIOLOGY/ULTRASOUND
- –MAMMOGRAM
- –OTHER:________________________

REVIEW OF RECORDS:

☐ PREVIOUS TEST RESULTS: ________________________

☐ DISCUSSION OF TEST RESULTS WITH PERFORMING PHYSICIAN: ________________________

☐ OLD RECORDS REVIEWED AND SUMMARIZED:________________________

☐ HISTORY OBTAINED FROM OTHER SOURCE:________________________

☐ INDEPENDENT REVIEW OF IMAGE/SPECIMEN: ________________________

DIAGNOSES/MANAGEMENT OPTIONS

☐ ESTABLISHED PROBLEM ☐ NEW PROBLEM

ASSESSMENT AND PLAN:

RISK OF COMPLICATIONS AND/OR MORBIDITY/MORTALITY:

☐ MINIMAL (EG, COLD, ACHES AND PAINS, OVER-THE-COUNTER MEDICATIONS)

☐ LOW (EG, CYSTITIS, VAGINITIS, PRESCRIPTION RENEWAL, MINOR SURGERY WITHOUT RISK FACTORS)

☐ MODERATE (EG, BREAST MASS, IRREGULAR BLEEDING, HEADACHES, MINOR SURGERY WITH RISK FACTORS, MAJOR SURGERY WITHOUT RISK FACTORS, NEW PRESCRIPTION)

☐ HIGH (EG, PELVIC PAIN, RECTAL BLEEDING, MULTIPLE COMPLAINTS, MAJOR SURGERY WITH RISK FACTORS, CHEMOTHERAPY, EMERGENCY SURGERY)

PATIENT COUNSELED ABOUT: ☐ SMOKING CESSATION ☐ CONTRACEPTION ☐ WEIGHT MANAGEMENT ☐ SAFE SEX ☐ EXERCISE ☐ OTHER

☐ **PATIENT EDUCATION MATERIALS PROVIDED**

MINUTES COUNSELED:	**TOTAL ENCOUNTER TIME:**
SIGNATURE:	**DATE: / /**

SAMPLE

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