OFFICE VISIT NOTE

Patient Information (Please Complete ALL Sections):

Patient First Name	Patient Last Name	Date of Birth	
Provider Name	Date of Office Visit	Time of Visit	Patient Sex

CHIEF COMPLAINT _____

_____

_____

HPI _____

_____

_____

_____

_____

VITAL SIGNS

WT _____ **HT** _____ **BP** _____**Pulse** _____ **Respirations** _____ **02 Sat** _____ **Temperature** _____

LAB RESULTS _____

_____

_____

MEDICATIONS & DOSES

Medication Name	Medication Strength	Medication Dose

LIST ALL MEDICATION ALLERGIES (Including reaction):_____

FAMILY HISTORY: Age at Death / Reason

Mother _____ / _____ Father _____ / _____ Sibling _____ / _____ Sibling _____ / _____

(Below, please circle any that apply to your family members. Mother = M, Father = F, Sibling = S)

M/F/S - Thyroid Disease **M/F/S - Diabetes** **M/F/S - Osteoporosis** **M/F/S - Blood Clots** **M/F/S - Cancer** **M/F/S - Ulcers**
M/F/S - High Blood Pressure **M/F/S - Stroke** **M/F/S - Mental Illness** **M/F/S - Heart Attack** **M/F/S - TB** **M/F/S - Alcoholism**

SOCIAL HISTORY:

Alcohol use: **# of drinks per day:_____**
Tobacco use: **Type:_____**
Coffee use: **# of drinks per day:_____**

Flu Vaccine Y N Date:_____
Tetanus Booster Y N Date:_____
Pneumonia Y N Date:_____ **Last Colonoscopy Date: _____Result: _____**
Hepatitis B Y N Date:_____

Patient Name: _____ **DOB:**_____

REVIEW OF SYMPTOMS: (Please check each item "yes" or "no" as they relate to your current health)

CONSTITUTIONAL:	Yes	No
Weight Loss/Gain	❑	❑
Fatigue	❑	❑
Fever	❑	❑

EYES:		
Glasses/Contacts	❑	❑
Eye Pain	❑	❑
Double Vision	❑	❑
Cataracts	❑	❑

EAR, NOSE, THROAT:		
Difficulty hearing	❑	❑
Ringing in ears	❑	❑
Vertigo	❑	❑
Sinus trouble	❑	❑
Nasal stuffiness	❑	❑
Frequent sore throat	❑	❑

CARDIOVASCULAR:		
Chest pain	❑	❑
Rapid Heart Rate	❑	❑
Palpitations	❑	❑
Elevated Blood Pressure	❑	❑
Dizziness	❑	❑
Varicose Veins	❑	❑

ENDOCRINE:		
Hair Loss	❑	❑
PMS	❑	❑
Irritability/Mood Swings	❑	❑
Hot flashes/ Night Sweats	❑	❑
Insomnia	❑	❑
Fatigue	❑	❑
Weight Gain	❑	❑
Impaired Memory	❑	❑

RESPIRATORY:	Yes	No
Cough	❑	❑
Coughing blood	❑	❑
Wheezing	❑	❑
Chills	❑	❑
Shortness of breath	❑	❑
Sputum Production	❑	❑

GASTROINTESTINAL		
Heartburn/Reflux	❑	❑
Nausea/Vomiting	❑	❑
Constipation	❑	❑
Change in BM's	❑	❑
Diarrhea	❑	❑
Jaundice	❑	❑
Abdominal Pain	❑	❑
Black or bloody BM	❑	❑
Difficulty Swallowing	❑	❑

GENITOURINARY:		
Blood in Urine	❑	❑
Pain / Burning Sensation	❑	❑
Trouble Urinating	❑	❑
Flank Pain	❑	❑
Frequency / Urgency		
Incontinence	❑	❑
Rash or Lesion	❑	❑
Discharge	❑	❑
Itching or Odor	❑	❑

PSYCHIATRIC:		
Mood Swings	❑	❑
Anxiety and/or Depression	❑	❑
Difficulty Sleeping	❑	❑
Suicidal Thoughts	❑	❑

SEXUAL HEALTH		
Loss of Sexual Desire	❑	❑
Loss of Sexual Sensation	❑	❑
Pain with Intercourse	❑	❑
Inability to Achieve Orgasm	❑	❑
Impotence	❑	❑

HEMATOLOGY/LYMPH:	Yes	No
Bruise easily	❑	❑
Gums bleed easily	❑	❑
Enlarged glands	❑	❑

MUSCULOSKELETAL:		
Joint Pain/Swelling	❑	❑
Stiffness	❑	❑
Muscle Pain	❑	❑
Back Pain	❑	❑

SKIN:		
Acne	❑	❑
Rash/Sores	❑	❑
Lesions	❑	❑
Itching/Burning	❑	❑

NEUROLOGICAL:		
Loss of Strength	❑	❑
Numbness	❑	❑
Headaches	❑	❑
Tremors	❑	❑
Memory Loss	❑	❑

FEMALES ONLY:

Last Mammogram/results:_____		_____
Last Pap/Results:	_____	_____
Age at onset of periods:_____		
Last menstrual period: _____		
Menses Cycle Regular?	❑	❑
Last DEXA Scan/Results: _____		_____
Are you on Replacement Hormones?	❑	❑
Current Birth Control?_____		
Number of Child Births? _____		
Are you currently pregnant?	❑	❑
Are you trying to become pregnant?	❑	❑
Heavy Periods	❑	❑
Painful Cramps	❑	❑
Vaginal Discharge/Itching	❑	❑
Vaginal Dryness	❑	❑
Nipple Discharge	❑	❑
Cysts in Breasts	❑	❑

Patient Name: _____ **DOB:**_____

PHYSICAL EXAM _____

ASSESMENT & PLAN_____

CPT CODES _____

RETURN TO OFFICE _____

_____	_____	_____
PROVIDER NAME	**PROVIDER SIGNATURE**	**DATE**