Medical Assistant_____ **Initials** ____ **Date**_____ **Time**_____

NAME:_____ **D.O.B.** _____ **Date:** _____

Date:

CHIEF COMPLAINT(S):

HISTORY OF PRESENT ILLNESS:

1. Location
2. Duration
3. Signs/Symptoms
4. Mod. Factors
5. Severity
6. Quality
7. Context
8. Timing

REVIEW OF SYSTEMS:

Skin: Other problems elsewhere on skin? ❑ Yes Where _____ ❑ No ❑ NA

Skin rashes in reaction to ❑ Medication ❑ Food ❑ Respiratory ❑ No ❑ NA

Add'l.: Wheezing ❑ Yes ❑ No ❑ NA Shortness of breath ❑ Yes ❑ No ❑ NA

Hypertension ❑ Yes ❑ No ❑ NA Exc. thirst or hunger ❑ Yes ❑ No ❑ NA

Musculoskeletal ❑ Yes Describe ❑ Arthralgia ❑ Limited motion ❑ _____ ❑ No ❑ NA

Gastrointestinal ❑ Yes Describe ❑ Cramping ❑ Pain ❑ Nausea/Vomiting ❑ _____ ❑ No ❑ NA

Other _____

PAST/FAMILY/SOCIAL HISTORY: (See Sheet Dated ____/____/____)

Sig. Findings/Changes: _____

AREA(S) EXAMINED:

	(Normal)	(Abnormal)	
❑ Scalp/Hair	____	____	_____
❑ Head/Face	____	____	_____
❑ Conj./Eyelids	____	____	_____
❑ Neck	____	____	_____
❑ Lips/Teeth/Gums	____	____	_____
❑ Chest/Breast/Axilla	____	____	_____
❑ Back	____	____	_____
❑ Abdomen	____	____	_____
❑ Genitalia/Groin/Buttocks	____	____	_____
❑ R ↑ Extrem.	____	____	_____
❑ L ↑ Extrem.	____	____	_____
❑ R ↓ Extrem.	____	____	_____
❑ L ↓ Extrem.	____	____	_____
❑ Digits/Nails	____	____	_____
❑ Oral Mucosa/Tongue	____	____	_____
❑ Lymphatic (Neck/Axilla/Groin)	____	____	_____
❑ Peripheral Vascular	____	____	_____
❑ _____	____	____	_____

MEDICAL DECISION MAKING: 1. Diag/Diff 2. Data Reviewed 3. Mgmt. Options 4. Risk Discussed 5. TX Plan

Minor Procedures:

_____ _____

Signature **Date**

NAME:_____ D.O.B. _____ Date: _____