

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:

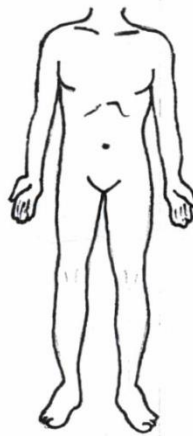
Signature _____

Date _____

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



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