

Name:

Date:

DOB:

Pt. #:

INITIAL EXAM

This is a ___ year old G ___ P ___ female ___ self-referred ___ referred for consultation by: _____

CC: (Required for all visits)

MEDICATIONS:

ALLERGIES:

Focused 99201 At least 1

HPI:

Location:

Expanded 99202 At least 1

Quality:

Severity:

Detailed 99203 At least 4

Duration:

Timing:

Mod Comp 99204 At least 4

Context:

Comp 99205 At least 4

Modifying Factors:

Associated Signs/Symptoms:

GYN HISTORY: Last pap ___ WNL ___ Abnl ___ Last exam ___ Last mammogram ___ WNL ___ Abnl ___ LMP ___ Menopause ___ Menstrual history ___ Vaginal deliveries ___ Cesarean deliveries ___

99201 No PFS Hx

PMH:

Yes/No Asthma Yes/No COPD Yes/No Kidney Infections Yes/No Kidney Stones Yes/No CHD Yes/No Stroke Yes/No Pneumonia Yes/No Depression/Anxiety Yes/No Seizures/Convulsions Yes/No Venereal Disease Yes/No Arrythmia Yes/No Migraines Yes/No Ulcers Yes/No Tuberculosis Yes/No SLE Yes/No Arthritis Yes/No Hypertension Yes/No Fibromyalgia Yes/No Cancer Yes/No GI problems Yes/No Glaucoma Yes/No Diabetes Yes/No Hepatitis Yes/No Thyroid Disease Type: Type: Type: Type: Type: Type: Type:

99203 At least 1 of 3

PSH: Previous incontinence surgeries? ___ No ___ Yes/Type: Surgeries:

99204 All 3 Required

FAMILY HISTORY:

Yes/No Heart Disease Yes/No Hypertension Yes/No Breast Disease Yes/No Stroke Yes/No Gyn Cancer Yes/No Other

SOCIAL HISTORY:

Marital Status ___ M ___ S ___ D ___ W ___ Sep Cigs ___/day Coffee ___ cups/day Caffeinated drinks (teas/soda) ___ cups/day Regular exercise ___ Yes ___ No

99201 No ROS

REVIEW OF SYSTEMS:

Skin ___ Neg ___ Rash ___ Other ___ Psychiatric ___ Neg ___ Seizure ___ Syncope ___ Neuropathy ___ Other ___ Neurologic ___ Neg ___ Depression ___ Anxiety ___ Other ___ Endocrine ___ Neg ___ Hot flashes ___ Diabetes ___ Thyroid ___ Other ___ Cardiovascular ___ Neg ___ Chest pain ___ Orthopnea ___ DOE ___ Other ___ Hematologic/Lymphatic ___ Neg ___ Easy bruising ___ Bleeding ___ Adenopathy ___ Other ___ Allergy/Immunol ___ Neg ___ Seasonal ___ Other ___ Eyes ___ Neg ___ Change in vision ___ Cataracts ___ Glaucoma ___ Other ___ ENT/Mouth ___ Neg ___ Ulcers ___ URI symptoms ___ Other ___ Respiratory ___ Neg ___ SOB ___ Wheezing ___ Other ___ Gastrointestinal ___ Neg ___ N/V ___ Diarrhea ___ Bloody stools ___ Other ___ Musculoskeletal ___ Neg ___ Weakness ___ Other ___ Constitutional ___ Neg ___ Weight change ___ Fatigue ___ Other ___ Genitourinary ___ Neg ___ Hematuria ___ Dysuria ___ Fecal incontinence ___ Other ___

Initial

Date