

HPI (History Of Present Illness): <input type="checkbox"/> Location <input type="checkbox"/> Severity <input type="checkbox"/> Timing <input type="checkbox"/> Modifying Factor <input type="checkbox"/> Quality <input type="checkbox"/> Duration <input type="checkbox"/> Context <input type="checkbox"/> Associated Signs and Symptoms CHIEF COMPLAINT:	BRIEF <i>1-3 elements</i>	BRIEF	EXTENDED <i>≥ 4 elements or status of ≥ 3 multiple chronic conditions</i>	EXTENDED
ROS (Review of Systems): <input type="checkbox"/> Constitutional (wt loss, etc) <input type="checkbox"/> Head, Ears, nose, mouth, throat <input type="checkbox"/> Eyes <input type="checkbox"/> Allergic/Immunologic <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> Respiratory <input type="checkbox"/> Psychiatric <input type="checkbox"/> Integumentary (skin, breast) <input type="checkbox"/> Hematologic/Lymphatic <input type="checkbox"/> Neurologic <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> "All others negative"	NONE	PERTINENT TO PROBLEM <i>1 system</i>	EXTENDED <i>2-9 systems</i>	COMPLETE <i>≥ 10 systems, or some systems with statement "all others negative"</i>
PFSH (Past Medical, Family, Social History): <input type="checkbox"/> Past history (the patient's past experiences with illnesses, operations, injuries and treatments) <input type="checkbox"/> Family history (a review of medical events in the patient's family, including disease which may be hereditary or place the patient at risk) <input type="checkbox"/> Social history (an age appropriate review of past and current activities)	NONE	NONE	PERTINENT <i>1 history area</i>	COMPLETE <i>2 or 3 history areas</i>
COMMENTS:	PROBLEM FOCUSED	EXPANDED PROBLEM FOCUSED	DETAILED	COMPREHENSIVE
EXAMINATION OF BODY AREAS: <input type="checkbox"/> Head, including face <input type="checkbox"/> Chest, including neck <input type="checkbox"/> Abdomen <input type="checkbox"/> Back, including spine <input type="checkbox"/> Genitalia, groin, buttocks <input type="checkbox"/> Each extremity EXAMINATION OF ORGAN SYSTEMS: <input type="checkbox"/> Constitutional <input type="checkbox"/> ENMT <input type="checkbox"/> Respiratory <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Psychiatric <input type="checkbox"/> Eyes <input type="checkbox"/> Cardiovascular <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> Skin <input type="checkbox"/> Neurologic <input type="checkbox"/> Hem/lymph/imm	PROBLEM FOCUSED <i>1 Body Area or System</i>	EXPANDED PROBLEM FOCUSED <i>2-4 systems</i>	DETAILED <i>5-7 Systems</i>	COMPREHENSIVE <i>8 or more systems</i>

MEDICAL DECISION MAKING			
A. NUMBER OF DIAGNOSIS OR TREATMENT OPTIONS			
1. _____	2. _____		
3. _____	4. _____ (+)		
		TOTAL: _____	
B. AMOUNT &/OR COMPLEXITY OF DATA TO BE REVIEWED			
1. _____	2. _____		
3. _____	4. _____ (+)		
		TOTAL: _____	
C. RISK OF COMPLICATION &/OR MORBIDITY OR MORTALITY			
_____		LEVEL: _____	
FINAL RESULT FOR COMPLEXITY			
STRAIGHT FORWARD	LOW	MODERATE	HIGH

PATIENT STATUS		NEW	ESTABLISHED		
VISIT STATUS	OUTPATIENT	INPATIENT	ED	SNF	HOME
HPI = _____	COMMENTS:				
EXAM = _____					
MDM = _____					
SERVICE = _____	CODED: _____				
SERVICE IS:	BILLABLE	NON-BILLABLE			
	UPCODED _____ LEVEL	DOWN CODED _____ LEVEL			

DATE OF SERVICE: _____	LAST NAME: _____
AUDITOR: _____	MRN: _____
PROVIDER: _____	