PATIENT PROGRESS NOTE

NAME: **AGE:** **LMP:** **DATE:**

PATIENT HISTORY

Chief Complaint:

HPI:

Medication Allergies: NKDA or:

Past Med/Surg/Family/Social History: ☐ reviewed/unchanged. New/Changes:

New Medications not on list:

Review of Systems ☐ As noted in CC / HPI. Document other positive / pertinent negative findings.

_____	Constitut	_____	Integ
_____	EENT	_____	Neuro
_____	Cardio	_____	Psych\Depression
_____	Resp	_____	Endo
_____	GI	_____	Heme/Lymph
_____	GU	_____	All/Immun
_____	MSk	_____	OB/GYN

PHYSICAL EXAMINATION

Ht: inch **Wt:** lbs **BMI:** **T:** **HR:** **RR:** **BP:** / **Pulse Ox:** **RA** **Liters**

Appearance: A & O *3 NAD **Other:**

Check box if normal examination performed. Document other positive findings / pertinent negative findings.

Eyes
- ☐ Pupils / Irises
- ☐ Conjunctiva / Lids
- ☐ Ophthalmoscopy

ENT
- ☐ External ears/nose
- ☐ Canals / TM's
- ☐ Hearing
- ☐ Nasal mucosa
- ☐ Lips/Teeth/Gums
- ☐ Oro/Post. Pharynx

Neck
- ☐ Neck
- ☐ Thyroid

Respiratory
- ☐ Effort
- ☐ Percussion
- ☐ Palpation
- ☐ Auscultation

Cardiovascular
- ☐ Palpation Heart
- ☐ Auscultation Heart
- ☐ Carotid Arteries
- ☐ Abdominal Aorta
- ☐ Femoral Arteries
- ☐ Pedal Pulses
- ☐ Edema/varicosities

Breasts
- ☐ Inspection
- ☐ Palpation

Skin
- ☐ Inspection
- ☐ Palpation

GI / Abdomen
- ☐ AbdExam/Mass/Tender
- ☐ Liver/Spleen
- ☐ Hernia exam
- ☐ Anus/Rectum
- ☐ Occ.Blood

GU / Male
- ☐ Scrotum
- ☐ Penis
- ☐ Prostate

GU / Female
- ☐ Genitalia/Vagina
- ☐ Urethra
- ☐ Bladder
- ☐ Cervix
- ☐ Uterus
- ☐ Adnexa

Lymph (2+ areas)
- ☐ Neck
- ☐ Axillae
- ☐ Groin
- ☐ Other

Psychiatric
- ☐ Judgment/Insight
- ☐ Orientation
- ☐ Memory
- ☐ Affect/Mood

Neurologic
- ☐ Cranial N's 2-12 G. Intact
- ☐ DTR ☐ Sensation

Musculoskeletal ☐ Gait and station ☐ Digits / Nails

Examination of one or more of the following six areas: ☐ Head and neck ☐ Spine / Ribs / Pelvis ☐ RUE ☐ LUE ☐ RLE ☐ LLE

NOTE: An "examination of an area" shall include ALL of the following: 1. Inspection/Palpation 2.Range of Motion 3.Stability 4. Strength/Tone

☐ See separate Osteopathic Structural Examination/Treatment sheet.

X-Rays

- ☐ Hand R L
- ☐ Wrist R L
- ☐ ForeArm R L
- ☐ Elbow R L
- ☐ Humerus R L
- ☐ Shoulder R L
- ☐ Hip R L
- ☐ Femur R L
- ☐ Knee R L
- ☐ Tib/Fib R L
- ☐ Ankle R L
- ☐ Foot R L
- ☐
- ☐ **C. Spine** ☐ **C-XRAY**
- ☐ **Thoracic** ☐ Rib
- ☐ **Lumbar** ☐ Abdom
- ☐ Nasal ☐ Pelvis
- ☐ Sinus ☐ KUB
- ☐ Other

Lab

- GlucoseFingerStick:
- RapidStrep:
- MonoSpot:
- UCG:
- UA:
  - Protein WBC's
  - Blood L.E.
- Hemoccult:

Lab Out

ECG

- Rate:
- S-T seg:
- Axis:
- T-wave:

Injections

- Drug:
- Site:
- Manuf:
- Lot:
- Exp:
- Initials:

PFT / Updraft-O2 Sat

- Pre:
- Post:
  - Good Eff Poor Eff

Other:

Diabete's Monitoring

Check every 3-6mnths

- ☐ **LABS**
  - HBAIC FLP
  - CMP U/A
- ☐ **Foot Exam**
  - Ulcers R L
  - Neuropathy R L
  - Fungus R L
  - Bony Change R L
  - Other
- ☐ **Nutrition Counsel**
  - Referral Y N
  - In-Office Y N
- ☐ **Refer for eye Exam**

HTN Monitoring

Check every 3-6mnths

- ☐ **LABS**
  - BMP or CMP
- ☐ **Nutrition Counsel**
  - Referral Y N
  - In-Office Y N

HyperChol/Lipid

Check every 3-6mnths

- ☐ **LABS**
  - CMP FLP
- ☐ **Nutrition Counsel**
  - Referral Y N
  - In-Office Y N

Pain Management

Check every 1-3mnths

- ☐ **LABS**
  - CMP UDS
- ☐ **Med Monitoring**
  - MAPS report

Tob Abuse/Counsel

Y N | Y N

- Tx:
- Refuses

Immunizations

- ☐ HEP A:
- ☐ HEP B:
- ☐ MMR:
- ☐ HPV:
- ☐ Varc/Zoster:
- ☐ Pneum:
- ☐ TD/Tdap:
- ☐ Meningoc:
- ☐ Influez:

E & M Ambulatory Exception Clinic

(Levels 1 - 3 and Intern / Resident completed > 6mos) ☐

I reviewed history, PE, diagnosis, and plan with the Intern / Resident and concur with any amendments.

(Levels 4 - 5 and/or Intern / Resident NOT completed > 6 mos) ☐

____ I saw and examined the patient. Discussed with the Resident and agree with the findings and plan as documented above.

____ I was present with the Resident during a key portion of the above documented exam/procedure/discussion. Case discussed with the Resident and agree with the findings and plan as documented above.

OMT: **Regions:** **Present** Y N

See Green OMT Sheet for Details

Notes:

Teaching Physician Signature / Date :