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

Expanded 99202 At least 1

Detailed 99203 At least 4

Mod Comp 99204 At least 4

Comp 99205 At least 4

HPI:

Location:

Quality:

Severity:

Duration:

Timing:

Context:

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

99202 No PFS Hx

99203 At least 1 of 3

99204 All 3 Required

99205 All 3 Required

PMH:

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

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

FAMILY HISTORY:

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

99202 At least 1

99203 At least 2-9

99204 At least 10

99205 At least 10

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 _____
Allergiy/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