**1. PATIENT INFORMATION**

- **a. Date of visit**
  - **Month**
  - **Day**
  - **Year**
- **b. ZIP Code**
- **c. Date of birth**
  - **Month**
  - **Day**
  - **Year**
- **d. Sex**
  - Female
  - Male
- **e. Ethnicity**
  - 1. Hispanic or Latino
  - 2. Not Hispanic or Latino
- **f. Race**
  - 1. White
  - 2. Black or African American
  - 3. Asian
  - 4. Native Hawaiian or Other Pacific Islander
  - 5. American Indian or Alaska Native
- **g. Tobacco use**
  - Not current
  - Current

**2. INJURY/POISONING/ADVERSE EFFECT**

- **a. Is this visit related to any of the following?**
  - Unintentional injury/poisoning
  - Intentional injury/poisoning
  - Injury/poisoning – unknown intent
  - Adverse effect of medical/surgical care or adverse effect of medicinal drug
  - None of the above

**3. REASON FOR VISIT**

- **a. As specifically as possible, list diagnoses disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).**
- **b. Regardless of the diagnoses written in 3a, does the patient now have –**
  - Arthritis
  - Asthma
  - Cancer
  - Depression
  - Diabetes
  - COPD
  - Obesity
  - Osteoporosis
  - Hyperlipidemia
  - Hypertension
  - Congestive heart failure
  - Schizophrenia

**4. CONTINUITY OF CARE**

- **b. Has the patient been seen in your practice before?**
  - Yes, established patient – How many past visits in the last 12 months? (Exclude this visit.)
- **c. Major reason for this visit**
  - New problem (<3 mos. onset)
  - Chronic problem, routine
  - Chronic problem, flare-up
  - Pre/Post surgery
  - Preventive care (e.g., routine prenatal, well-baby, screening, insurance, general exams)

**5. PROVIDER’S DIAGNOSIS FOR THIS VISIT**

**6. VITAL SIGNS**

- **a. Weight**
  - lb
  - oz
- **b. Height**
  - in
  - cm
- **c. Temperature**
  - °F
  - °C
- **d. Blood pressure**
  - Systolic
  - Diastolic

**7. DIAGNOSTIC/SCREENING SERVICES**

- **3. Examinations**
  - Breast
  - Foot
  - Pelvic
  - Rectal
  - Retinal
  - Skin
  - Depression screening
  - Imaging: X-ray
  - Bone mineral density
  - CT scan
  - Echocardiogram
  - Other ultrasound

**8. HEALTH EDUCATION**

- **a. Mark (X) all ordered or provided at this visit.**
  - 1. Niacin
  - 2. Injury prevention
  - 3. Stress management
  - 4. Tobacco use/Exposure
  - 5. Weight reduction
  - 6. Other

**9. NON-MEDICATION TREATMENT**

- **a. Mark (X) all ordered or provided at this visit.**
  - 1. Physical therapy
  - 2. Speech/Occupational therapy
  - 3. Physical therapy
  - 4. Wound care
  - 5. Cast
  - 6. Splint or wrap

**10. MEDICATIONS & IMMUNIZATIONS**

- **a. Mark (X) all providers seen at this visit.**
  - 1. Physician
  - 2. Physical therapist
  - 3. Other

**11. PROVIDERS**

- **a. Mark (X) all providers seen at this visit.**
  - 1. Physician
  - 2. Physical therapist
  - 3. Other

**12. TIME SPENT WITH PROVIDER**

- **a. Use patient’s own words.**

**13. PATIENT RECORD**

- **a. As specifically as possible, list diagnoses disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).**
- **b. Regardless of the diagnoses written in 1a, does the patient now have –**
  - Arthritis
  - Asthma
  - Cancer
  - Depression
  - Diabetes
  - COPD
  - Obesity
  - Osteoporosis
  - Hyperlipidemia
  - Hypertension
  - Congestive heart failure
  - Schizophrenia

- **a. Tobacco use**
  - Not current
  - Current

- **b. Was patient referred for this visit?**
  - Yes
  - No

- **c. Major reason for this visit**
  - New problem (<3 mos. onset)
  - Chronic problem, routine
  - Chronic problem, flare-up
  - Pre/Post surgery
  - Preventive care (e.g., routine prenatal, well-baby, screening, insurance, general exams)

- **a. Date of visit**
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  - **Day**
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- **3. REASON FOR VISIT**

- **4. CONTINUITY OF CARE**

- **5. PROVIDER’S DIAGNOSIS FOR THIS VISIT**

- **6. VITAL SIGNS**

- **7. DIAGNOSTIC/SCREENING SERVICES**

- **8. HEALTH EDUCATION**

- **9. NON-MEDICATION TREATMENT**

- **10. MEDICATIONS & IMMUNIZATIONS**

- **11. PROVIDERS**

- **12. TIME SPENT WITH PROVIDER**

- **13. PATIENT RECORD**

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- **12. TIME SPENT WITH PROVIDER**