ACCOMPANIED BY	PREFERRED LANGUAGE	DATE/TIME	Name

DRUG ALLERGIES	CURRENT MEDICATIONS	ID NUMBER

WEIGHT (%) See growth chart.	HEIGHT (%)	BMI (%)	TEMPERATURE	BIRTH DATE	AGE	M F	NURSE SIGNATURE

TEMP _____ AX R O T | RESP | PULSE | BP | SpO_2

Chief Complaint

_____

_____

Immunization current for age ☐ Yes ☐ No See Immunization Record.

History (location, timing, quality, severity, context, or modifying factors)

Yes	No		Days	
☐	☐	Fever (max)		
☐	☐	Cough		
☐	☐	Nasal congestion		
☐	☐	Sore throat		
☐	☐	Earache ☐ R ☐ L		
☐	☐	Vomiting		
☐	☐	Diarrhea		
☐	☐	Abdominal pain		
☐	☐	Headache		
☐	☐	Rash		
☐	☐	Wheeze		
☐	☐	_____		

Review of Systems

Problem List ☐ No interval change

Past medical history (see Initial History Questionnaire) ☐ No interval change

Pertinent negatives

_____

_____

Social/Family History

See Initial History Questionnaire. ☐ No interval change

Physical Examination

☑ Examined and normal

☐ GENERAL APPEARANCE	☐ NEUROLOGIC
☐ NECK	☐ HEAD
☐ RESPIRATORY	☐ EYES
☐ CARDIOVASCULAR	☐ EARS, NOSE, MOUTH, AND THROAT
☐ GASTROINTESTINAL	☐ CHEST
☐ GENITOURINARY	☐ BACK
☐ GENITALIA	☐ MUSCULOSKELETAL
☐ EXTREMITIES	☐ MENTAL STATUS
☐ SKIN	

Findings and comments related to chief complaint.

_____

_____

_____

_____

_____

Diagnosis

_____

Plan

☐ See other side _____

_____

Follow-up/Next visit ☐ PRN _____ days/weeks/months

Print Name	Signature
PROVIDER 1	
PROVIDER 2	

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Problem Visit

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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