The newly revised American Academy of Pediatrics (AAP) Problem Visit form is designed to provide health care professionals with the resource they need to appropriately document activities within the acute illness visit, support appropriate coding, and secure appropriate payment for their activities. The majority of evaluation and management (E/M) coding specifies certain levels of data elements that must be present to justify the various levels of payment. This is most clearly seen with the office or other outpatient service codes (99201–99215) or reporting the problem or acute illness visit.

With an increase in pay-for-performance programs, quality improvement initiatives, audits, and legal review, documentation is more critical than ever. The AAP Problem Visit form will assist in simplifying the documentation process. By providing an organized and consistent layout, clinicians can use the form for more effective documentation, which can improve performance, limit liability, and support efforts to obtain appropriate payment for services. While the electronic medical record will be the future for most medical practices, this Problem Visit form provides a clear, concise way for practitioners to meet their current documentation needs during the acute illness visit.

**Key Features**

**Single-Page Form**
To complement the AAP Visit Documentation Forms, the Problem Visit documents activities during acute illness visits. As with the documentation forms, the Problem Visit form is on a single page. The front contains prompts for the most common issues that present during acute illness visits. The Problem Visit form uses check boxes where feasible, but space is provided for written information where appropriate. Additional notes may be written on the back of the form.

**Reduced Duplication**
To decrease the need for duplication of information, the Problem Visit form extensively references other key components from the AAP collection of documentation products. These include references to the Initial History Questionnaire (birth history, past history, and family history), Problem List, and Vaccine Administration Record. The same Problem Visit form can be used for all ages covered by the documentation forms.

**Universality**
No documentation form will completely satisfy all practitioners. However, the Problem Visit form conforms to the most widely recognized set of information that pediatricians should obtain during the visit. The form also has been designed to be consistent with Centers for Medicare & Medicaid Services documentation guidelines to support E/M coding. While efforts have been made to address common documentation requirements for Early and Periodic Screening, Diagnosis, and Treatment, states vary in their required elements. Additional elements may be needed to meet your state’s requirements.

**Peer Reviewed**
The Problem Visit form has been reviewed by multiple AAP committees, including the Committee on Adolescence, Committee on Coding and Nomenclature, Committee on Medical Liability and Risk Management, Committee on Practice and Ambulatory Medicine, and Council on Clinical Information Technology.
### Visit Documentation Form User Guide for Problem Visit

#### Conforms to E/M documentation guidelines.

- Information essential to an acute or problem visit.
- Reference to Initial History Questionnaire and Problem List decreases need to repeat pertinent information.
- Plan and follow-up may use other side if additional space needed.

#### Vital signs.

- **Temperature**
- **Axial**
- **Respiratory**
- **Eyes**
- **Cardiovascular**
- **Ears, nose, mouth, and throat**
- **Gastrointestinal**
- **Chest**
- **Genitourinary**
- **Back**
- **Genitalia**
- **Mental status**
- **Skin**

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

- **Chief Complaint**
- Immunization current for age
- **Yes**
- **No**
- **See Immunization Record.**

#### Review of Systems

- **Pertinent negatives**
- **Social/Family History**
- **No interval change**
- **See Initial History Questionnaire.**

#### Physical Examination

- **Findings and comments related to chief complaint.**
- **Check boxes** indicate normal.
- **No check and no comment indicate not examined.**

#### Diagnostics

- **Plan**
- **Follow-up/Next visit**
- **Problem Visit**

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*American Academy of Pediatrics*  
*Dedicated to the Health of All Children*

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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