

ANNUAL PHYSICAL EXAMINATION FORM

Please complete all information to avoid return visits.

Part One: TO BE COMPLETED PRIOR TO MEDICAL APPOINTMENT

Name: _____
Address: _____

Date of Exam: _____
SSN: _____
Date of Birth: _____

Sex: ☐ Male ☐ Female

Name of Accompanying Person: _____

DIAGNOSES/SIGNIFICANT HEALTH CONDITIONS: *(Include a Medical History Summary and Chronic Health Problems List, if available)*

CURRENT MEDICATIONS: *(Attach a second page if needed)*

Medication Name	Dose	Frequency	Diagnosis	Prescribing Physician Specialty	Date Medication Prescribed

Does the person take medications independently? ☐ Yes ☐ No

Allergies/Sensitivities: _____

Contraindicated Medication: _____

IMMUNIZATIONS:

Tetanus/Diphtheria *(every 10 years)*: _____ / _____ / _____ Type administered: _____

Hepatitis B: #1 _____ / _____ / _____ #2 _____ / _____ / _____ #3 _____ / _____ / _____

Influenza (Flu): _____ / _____ / _____

Pneumovax: _____ / _____ / _____

Other: *(specify)* _____

TUBERCULOSIS (TB) SCREENING: *(every 2 years by Mantoux method; if positive initial chest x-ray should be done)*

Date given _____ Date read _____ Results _____

Chest x-ray (date): _____ Results _____

Is the person free of communicable diseases? ☐ Yes ☐ No *(if no, list specific precautions to prevent the spread of disease to others)*

OTHER MEDICAL/LAB/DIAGNOSTIC TESTS:

GYN exam w/PAP: Date _____ Results _____
(women over age 18)

Mammogram: Date: _____ Results: _____
(every 2 years- women ages 40-49, yearly for women 50 and over)

Prostate Exam: Date: _____ Results: _____
(digital method-males 40 and over)

Hemocult Date: _____ Results: _____

Urinalysis Date: _____ Results: _____

CBC/Differential Date: _____ Results: _____

Hepatitis B Screening Date: _____ Results: _____

PSA Date: _____ Results: _____

Other *(specify)* _____ Date: _____ Results: _____

Other *(specify)* _____ Date: _____ Results: _____

HOSPITALIZATIONS/SURGICAL PROCEDURES:

Date	Reason	Date	Reason

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physician provider spends on documentation as many of the mandatory elements are no longer a requirement for calculating a code level Previously an E M evaluation and management note required documentation of history exam and medical decision making with required elements in each component to support a level for payment If an element was missing the level of service was not supported therefore the code was lowered resulting in a lower reimbursement for the physician provider The new guidelines eliminated the requirement of History and Exam as part of the calculation of a code level Yes an appropriate history and exam are required this supports good patient care but when it comes to reimbursement they are no longer part of the picture The overall system is not difficult if time is taken to understand the elements and how they are applied in the documentation Documentation is a word game always has been the authors focus is to show what words to use to lessen the time but still convey the complexity of the patient s condition and how the physician provider determines a treatment plan which includes the risk to the patient to satisfy the Coding guidelines initiated by Medicare and American Medical Association This book evaluates the new guidelines and brings them into prospective so physicians providers coders can easily understand how to document and calculate the level of service for reimbursement This is not a cumbersome book or complicated but straight to the point The main goal of the book is to educate physicians nurses and coders on what documentation is really required and what has just become habit over the last 30 years

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increase in complexity throughout the day and week NEW text discussions provide context for on the job reference especially on insurance and coding NEW illustrations include realistic patient forms and screen shots **Federal Register** ,2012-04

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