

# 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 |
|------|--------|------|--------|
|      |        |      |        |
|      |        |      |        |

# Annual Physical Form For Patients

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*The New Face of Evaluation and Management* Kellie Hall, 2025-06-30 Physicians want to care for patients not spend their time documenting in an electronic medical record Physicians are always complaining about the amount of time they spend documenting patient care in support of medical billing through an evaluation and management coding system E M New guidelines were created to lessen the time a 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 perspective 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. **Medical Insurance Made Easy**

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web this pilots guide provides information to aid in this and is divided up into six sections the first section provides general familiarization of each autopilot system including the associated panel mounted displays the second section describes the kap 140 single axis autopilot system