

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

Kellie Hall

A red circular graphic with a gradient, appearing as a semi-circle or a partial circle, located to the right of the name Kellie Hall.

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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**

- E-Book Jill Brown, 2013-08-02. Features completely updated information that reflects the many changes in the insurance industry. Contains a new chapter on UB 92 insurance billing for hospitals and outpatient facilities. Includes a new appendix Quick Guide to HIPAA for the Physician's Office to provide a basic overview of the important HIPAA related information necessary on the job. *Medical Record Administration and Health Care Documentation* United States. Department of the Army, 1999. *Program Development Handbook for State and Local Agencies on Nursing Home Ombudsman Services for the Elderly* Community Research Applications, Inc, 1978. *Medical Scribe Certification Exam Prep 2025-2026* Neal Phoebe Hardin, Transform your healthcare career with the most comprehensive medical scribe certification preparation available. This complete study guide provides everything needed to pass the Medical Scribe Certification Exam MSCE and Certified Medical Scribe Professional CMSPE examinations on your first attempt. What's Inside: 500 practice questions with detailed explanations. Complete coverage of medical terminology, anatomy and physiology, HIPAA compliance and legal documentation requirements, Electronic Health Records (EHR) systems training for Epic, Cerner and major platforms, Clinical workflow optimization and provider interaction techniques, Pharmacology essentials for medical scribes, Specialty specific documentation for emergency medicine, surgery, cardiology and more. Professional development and career advancement strategies. Four full length practice examinations simulating real MSCE conditions. Master Essential Skills SOAP note documentation and clinical workflows. Medical abbreviations and terminology recognition. Digital security for remote scribing positions. Quality assurance and error prevention techniques. Professional boundaries and ethical practice standards. This study guide bridges the gap between basic training and professional competency covering everything from entry level concepts to advanced specialty documentation. Each chapter builds systematically on previous knowledge while providing practical examples from real clinical scenarios. Perfect for Aspiring medical scribes seeking certification. Healthcare professionals transitioning to scribe roles. Current scribes preparing for advancement. Students in pre medical and health administration programs. Remote workers entering virtual scribing positions. Stop struggling with scattered study materials. This comprehensive guide provides structured preparation that builds confidence and ensures certification success. Join thousands of certified medical scribes who have launched successful healthcare careers with proper preparation. Bonus Features: Scoring guides for self assessment. Study timelines and preparation strategies. Industry trends and future outlook.

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