E&M ELEMENTS

CATEGORY 1- HISTORY:

CHIEF COMPLAINT (CC)

- The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

HISTORY OF PRESENT ILLNESS (HPI)

- **Location** - Location of sign/symptom. Where the problem is located. Body part or general area. (e.g.) left arm, abdomen, throat.
- **Quality** - Descriptive word about the quality of the symptoms. (e.g.) painful, stabbing, dull, constant, squeezing, throbbing, stable.
- **Timing** - Frequency (e.g.) once a day; weekly; hourly.
- **Duration** - Date of onset of sign/symptom that patient is being seen for. (e.g.) today; last week; diagnosed 01/1/01.
- **Severity** - Description of the level of pain, from mild to severe. (e.g.) on a scale of 1 to 10; improved; worsening; comparative statements- “like labor”; staging-stage 2b
- **Context** - Activity or situation associated with the complaint. What the patient does that aggravates or relieves the symptoms. (e.g.) lying down; standing, walking down stairs, lifting weights.
- **Modifying Factors** - Action taken prior to being seen by the physician, to alleviate discomfort and the results. (e.g.) patient applied ice pack, which reduced the swelling.
- **Associated Sign/Symptom** - Other system or body area complaint associated with the presenting problem. Other problem that might contribute to the chief complaint. (e.g.) Patient being seen for chest pain, and has *shortness of breath*.

REVIEW OF SYSTEMS (ROS)

- **Constitutional Symptoms**
  (e.g., fever, weight loss)
- **Eyes**
- **Ears, Nose, Mouth, Throat**
- **Cardiovascular**
- **Respiratory**
- **Gastrointestinal**
- **Genitourinary**
- **Musculoskeletal**
- **Neurological**
- **Psychiatric**
- **Integumentary**(skin, and/or breast)
- **Endocrine**
- **Hematologic/Lymphatic**
- **Allergic/Immunologic**
- **All Other Systems Negative** (When all positive and pertinent negative responses are individually documented, this may be used to indicate all remaining systems are negative.)
PAST, FAMILY, SOCIAL HISTORY (PFSH)

- **Past History** - The patient’s past experiences with illnesses, operations, injuries and treatments. (e.g.) HTN - Currently on Lopressor; Hip replacement 1997; NIDDM, history of childhood chicken pox and measles.

- **Family History** - A review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk. (e.g.) Father with CAD, Mother died of breast cancer, Age 57; Fraternal uncle-IDDM; Family alive and well.

- **Social History** - An age appropriate review of past and current activities. (e.g.) Pack a day smoker for past 15 yrs; Social alcohol use; Denies smoking, alcohol, IV drug use; Widowed, lives alone; History of exposure to asbestos at place of work.

CATEGORY 2- PHYSICAL EXAMINATION:

PHYSICAL EXAMINATION (1995 GUIDELINES)

**Body Areas**

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

**Organ Systems**

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, Nose, Mouth and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic
**CATEGORY 3 - MEDICAL DECISION MAKING:**

The levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- **Number of Diagnosis or Management Options** - The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

  *Hints: Document all diagnoses addressed during the encounter: Minor/self-limited problem(s) or an established problem(s), which is stable/improved; Established problem(s) that is worsening; New problem; New problem(s) requiring additional work-up.*

- **Amount and/or Complexity of Data to be Reviewed** - The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed.

  *Hints: Document as appropriate: Any review and/or order of clinical lab tests; Radiology tests (x-ray, MRI, CT, nuclear med, etc.); Medical tests (EEG, EKG, echos, cardiac caths, etc); Discussion of test results with the performing physician; Decision to obtain and review old medical records and/or obtain history from other sources other than the patient; Independent review of image, tracing or specimen; Review and summarization of old records and/or obtaining history from someone other than the patient and/or discussion of case with another health provider (not a resident).*

- **Risk of Significant Complications, Morbidity, and/or Mortality** - The significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

  *Hints: Document as appropriate: {1} Each presenting problem(s) {2} Each diagnostic procedures(s) ordered in relation to the presenting problem(s) {3} Each management option(s) in relation to the presenting problem(s).*