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 (straight forward, 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).