New York Presbyterian Hospital
Department of ____________________________

Date ____
Name____
MRN ____
DOB ____

Circle type of service:
Consult **Name of referring physician (consult)**____
Initial office visit
Subsequent office visit

Chief Complaint / Reason for Encounter ____
____

Describe present illness/complaint (location, severity, timing, context, etc.)____
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Family history____
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Social history____
____

Past medical history____
____

Current medications: ____
____
____
____
____

Review of Systems		Findings
Constitutional symptoms	Fever, weight loss, fatigue, repeated infections	
Eyes	Double, decreased or blurred vision, red eye, glaucoma, change in glasses, cataracts	
Ears, Nose Mouth, Throat	Decreased hearing, discharge, infections, stuffiness, hoarseness, change in voice, difficulty swallowing, loose or capped teeth	
Respiratory	SOB, asthma, bronchitis, coughing, pain with breathing, TB, abnormal CXR	
Cardiovascular	Chest pain, palpitations, tachycardia, high blood pressure, SOB, abnormal ECG, heart attack	
Gastrointestinal	GB, ulcer, food intolerance, diet change, jaundice, hepatitis, N/V	
Genitourinary	Kidney failure, stones, difficulty with urination, sexual dysfunction	
Integumentary	Breast lumps or mass, rashes, psoriasis, moles, skin cancer	
Musculoskeletal	Joint aching, LBP	
Psychiatric	Depression, psychosis, hearing voices	
Endocrine	Thyroid disease, diabetes	
Hematological/ Lymphatic	Low Hct, blood transfusions, lymph node enlargement, bleeding, bruising	
Allergic	Rhinitis, hay fever	
Neurological	Weakness, headache, seizures, speech disturbances, cognitive changes, clumsiness, numbness	

All other systems negative. **Yes**__________ ______________**(Initials)**

Name:____
MRN:____
T:____________ **Pulse**:____________ **Resp**:________________ **Ht**.:________________ **Wt**.:__________________

EYES:

ENT:

LYMH:

RESP:

CARDIO:

VASCULAR:

ABD:

SKIN:

MUSCSKEL:

EXTS:

NEURO:

PSYCH:

BREASTS:

GENITOURINARY:

Labs, Reports, and Films reviewed and /or ordered:

***Assessment and Plan*:**

Signature: ____
Service Code: ____
Time (total time or start/end)____
11/98