Chief Complaint must be documented.		Exp. Problem Focused	Detailed	Comprehensive
HPI:LocationSeverityTimingModifying FactorQualityDurationContextAssociated sign/symptom	1-3	1-3	4+	4+
Review of Systems: ConstitutionalEyesENMTMusculoNeuroIntegumentaryGICardioRespHem/LymphEndoPsychAllergy/ Immuno	None	1	2-9	10+ or "All others reviewed & negative"
Past History: medications, past illness, surgeries, allergies to medsFamily History: medical events/disease in familySocial History: marital status, education, use of drugs, tobacco, etc.	None	None	1	3*

*Complete PFSH: 2 HX areas for Est pts. Office, Domiciliary, Home, Emergency Dept, Subseq Nursing Facility 3 HX areas for New pts. Office, Consultation, Initial Hospital, Hospital Obs, Comp Nursing facility assessment

Body AreasHead/FaceChest/BreastAbdomenBack/SpineNeckGenitalia/groin/buttocksExtremities Organ SystemsConstitutionalEyesENMTCVRespGIGUSkinNeuroMusculoskeletalPsychHem/Lymph/Immuno	1 Area or Organ system	2-7 Areas &/or Organ systems	2-7 Areas &/or Organ Systems; 1 in Detail	8+ Organ Systems Only
Cardiovascular Bullets listed on back.	1-5 Bullets	6 Bullets	12 Bullets	All bullets in shaded borders & 1 in each unshaded

BOX A: Number Of Diagnosis or Management Options (N x P = R)								
Problems			Number		Points		Results	
Self-limited or minor (stable, improvorsening)	roved or		Max = 2		1			
Est. problem: stable or improving					1			
Est problem: worsening					2			
New problem: no additional work	-up planned		Max = 1		3			
New problem: additional work-up	planned				4			
Bring to line A in Final Result f	or MDM				Tot	al		
BOX B: Amount and/or Co	mplexity of	Data	to be rev	view	red .		Points	
Review and/or order of clinical lab test						1		
Review and/or order of tests in the radiology section of CPT						1		
Review and/or order of tests in the medicine section of CPT					1			
Discussion of test results with performing physician					1			
Decision to obtain old records and/or obtaining history from someone other than patient					1			
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider					2			
Independent visualization, tracing or specimen itself (not simply review of report)					2			
Bring to line B in Final Result for MDM Total				al				
BOX D: Final Result for Complexity of Medical Decision Making: 2 of 3 required								
A Number of diagnoses or management options	≤ 1 Minimal	Li	2 mited	١	3 Multiple		≥ 4 Extensive	
B Amount and complexity of data to be reviewed	≤ 1 Minimal	Li	2 mited	1	3 Multiple	ı	≥ 4 Extensive	
C Risk of complications and/or morbidity or mortality	Minimal		Low	N	loderate		High	
TYPE OF DECISION MAKING	Straight Forward		Low oplexity		oderate mplexity	С	High omplexity	

BOX C: Risk of Complication and/or Morbidity or Mortality						
	Presenting Problems	Diagnostic Procedures ordered	Management Options Selected			
MINIMAL	1 self-limited or minor problem (eg. Cold, insect bite, tinea corporis	Lab tests requiring venipuncture EKG/EEG Urinalysis Ultrasound X-RAYS KOH prep	Rest Gargles Elastic bandages Superficial dressings			
TOW	2 or more self-limited or minor problems 1 stable chronic illness Acute uncomplicated illness or injury	Physiologic test not under stress Non-cardiovascular imaging Superficial needle biopsies Clinical lab test requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery w/ no identified risk factors Physical therapy Occupational therapy IV fluids without additives			
MODERATE	1 or more chronic illnesses w/mild exacerbation, progression or side effects of treatment 2 or more stable chronic illnesses Undiagnosed new problem w/ uncertain prognosis Acute illness with systemic symptoms Acute complicated injury	Physiologic test under stress Jiagnostic endoscopies w/no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies w/contrast, no identified risk factors Obtain fluid from body cavity	Minor surgery with identified risk factors Elective major surgery (open, percut, or endoscopic) no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation w/o manipulation			
HIGH	1 or more chronic illnesses w/ severe exacerbation, progression, side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function Abrupt change in neurologic status	Cardiovascular imaging studies w/contrast w/ identified risk factors Cardiac eletrophysiological tests Diagnostic endoscopies w/indentified risk factors Discography	Elective major surgery (open, percut or endoscopic) w/ identified risk factors Emergency major surgery (open, percut, or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis			

System/Body Area	Elements of Examination
Constitutional	 Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Eyes	Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat	 Inspection of oral mucosa, notation of presence of pallor or cyanosis Inspection of lips, teeth and gums
Neck	 Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)
	Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	 Palpation of heart (eg, location, size and forcefulness of the point of maximal impact;thrills; lifts; palpable S3 or S4) Auscultation of heart with notation of abnormal sounds and murmurs Examination of: carotid arteries (eg, waveform, pulse amplitude, bruits, apical-carotid delay) abdominal aorta (eg, size, bruits) femoral arteries (eg, pulse amplitude, bruits) pedal pulses (eg, pulse amplitude) extremities for edema and/or varicosities
Gastrointestinal (Abdomen)	 Examination of abdomen with notation of presence of masses or tenderness Examination of liver and spleen Obtain stool sample for occult blood test when indicated
Musculoskeletal	 Examination of the back with notation of kyphosis or scoliosis Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
Extremities	• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, stasis dermatitis, ulcers, scars, xanthomas)
Neurologic/	Brief assessment of mental status including
Psychiatric	 Orientation to time, place and person, Mood and affect (eg, depression, anxiety, agitation)