New York House Call Physicians®

YOUR DOCTOR IN THE FAMILY

TODAY'S DATE___Month___/__Day____/_Year

Patient Name____

Patient Date of Birth_______________________________________

New York House Call Physicians® Progress Note

Chief Complaint & HPI____

____

Medications____

PMHx: ____

Family Hx: ____

Allergies: ____

Social Hx: ____

ROS:

GEN/HEENT		CV/PULM		GI/GU		MSK/ NEURO/PSYCH		OTHER	
F/C/S	□ Y □ N	CHEST PAIN	□ Y □ N	NAUSEA	□ Y □ N	JOINT PAIN	□ Y □ N	WEIGHT LOSS	□ Y □ N
FATIGUE	□ Y □ N	DYSPNEA	□ Y □ N	VOMITTING	□ Y □ N	JOINT SWELLING	□ Y □ N	WEIGHT GAIN	□ Y □ N
ITCHY EYES	□ Y □ N	PLEURITIC PAIN	□ Y □ N	DIARRHEA	□ Y □ N	MYALGIAS	□ Y □ N		□ Y □ N
EAR PAIN L &/OR R	□ Y □ N	COUGH	□ Y □ N	MELENA/ HEMATOCHEZIA	□ Y □ N	PARESTHESIAS	□ Y □ N		□ Y □ N
RUNNY NOSE	□ Y □ N	ORTHOPNEA	□ Y □ N	ABD PAIN	□ Y □ N	DEPRESSED MOOD	□ Y □ N		□ Y □ N
SORE THROAT	□ Y □ N	PND	□ Y □ N	DYSURIA	□ Y □ N	SUICIDALITY	□ Y □ N		□ Y □ N
SINUS PAIN OR PRESSURE	□ Y □ N	LEG EDEMA	□ Y □ N	HEMATURIA	□ Y □ N	ANXIETY	□ Y □ N		□ Y □ N
TOOTH PAIN	□ Y □ N	NOCTURIA	□ Y □ N	URINARY FREQUENCY	□ Y □ N		□ Y □ N		□ Y □ N

Vitals: T=_______ Pulse=_______ BP=______/______ R=_______ 02 Sat=_______ HT=_______ WT=______

Physical Exam	Normal	Comment here on abnormal findings
HEENT		
CV		
LUNGS		
ABD		
EXT		
NEURO		
PSYCH		
LYMPH		
SKIN		
GU/RECTAL		

Medical Provider Name____

Medical Provider Signature____

Today's Date____

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LAB AND SPOT DIAGNOSTIC TESTING

UA: □ Not Done □ Negative □ Positive____

Rapid Strep Test: : □ Not Done □ Negative □ Positive

Other: ____

Diagnosis/Impression/Plan:

My differential diagnosis and working diagnosis were explained to the patient. Treatment and alternative treatment options were reviewed. Risks, benefits, and potentially adverse effects of treatment were explained. Verbal and written information on diagnosis and treatment was provided. Follow-up within 24 hours advised if no improvement. Patient demonstrated understanding.

Yes □ No □

Medication(s) Dispensed &/or Injected (include Name of Medication, Lot #, Expiration Date, Quantity):

____

____

____

ICD-9 Codes (check all that apply): □ Back Pain (724.5) □ Bronchitis, Acute (466.0) □ Cough (786.2) □ Diarrhea (787.91) Dizzyness/Vertigo (780.4) □ Fatigue (780.79) □ Fever (780.6) □ Nausea (787.01) □ Pharyngitis (462) □ UTI (595.0)
Other ICD-9:____

CPT Codes: □ Physician House Call New Patient (99345) □ Physician House Call Established Patient (99350)

Medical Provider Name____

Medical Provider Signature____

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