DRID: _____
PRID: _____

1. PATIENT INFORMATION

a. Date of visit _____/_____2011 (Day/Month) **b. Sex** 1❑ Female 2❑ Male **c. Age** _____

d. Ethnicity 1❑ Hispanic or Latino 2❑ Not Hispanic or Latino

f. Race 1❑ White 2❑ Black or African American 3❑ Asian 4❑ Native Hawaiian or other Pacific Islander 5❑ American Indian or Alaska Native

g. Expected source(s) of payment for this visit – *Mark(X) all that apply*.
1❑ Private Insurance 2❑ Medicare 3❑ Medicaid 4❑ Worker's Comp. 5❑ Self-pay
6❑ No charge/charity 7❑ Other 8❑ Unknown

h. Tobacco Use 1❑ Currently use 2❑ Do not currently use 3❑ Unknown

2. INJURY/POISONING/ADVERSE EFFECT (Is this visit related to any of the following?)

1❑ Adverse effect of medical/surgical care or adverse effect of medicinal drug 2❑ Other_____

3. REASON FOR VISIT – Patient's complaint(s), symptom(s), other reason(s) for visit

(1) Most Important: _____
(2) Other: _____
(3) Other: _____

4. CONTINUITY OF CARE

a. Was patient referred for this visit?
1❑ Yes 2❑ No 3❑ Unknown

b. Has the patient been seen in your practice before?
1❑ Yes, established patient-how many visits in last 12 months? (Exclude this visit) _____
2❑ No, new patient.

c. Major reason for this visit: 1❑ New problem (< 3 mos. Onset) 2❑ Chronic problem, routine
3❑ Chronic problem, flare-up 4❑ Pre/Post surgery 5❑ Preventive care (e.g., routine prenatal, well-baby screening, Insurance, general exams)

5. PROVIDER'S DIAGNOSIS FOR THIS VISIT

a. As specifically as possible, list diagnoses related to this visit including chronic conditions.
(1) Primary Dx: _____
(2) Other: _____

b. Regardless of the diagnoses written in 5a, does the patient now have – *Mark (X) all that apply.*

1❑Arthritis	2❑ Asthma	3❑ Cerebrovascular	4❑ Chronic renal failure	5 ❑Congestive heart failure
6❑ COPD	7❑ Depression	8❑Diabetes	9❑ Hyperlipidemia	10❑ Hypertension
11❑ Ischemic heart disease	12❑ Obesity	13❑ Osteoporosis	14❑ None of the above	

6. VITALS & DIAGNOSTIC SERVICES

a. Height _____**ft** ____**in. b. Weight** _____**lbs** **c. BMI**_____ **d. Blood Pressure** _____ **/** _____
Systolic **Diastolic**

Mark (x) all *ordered* or *provided* at this visit. 1❑ None
Examinations:
2❑ Breast 3❑ Foot 4❑ Pelvic 5❑ Rectal 6❑ Retinal 7❑ Skin 8❑ Depression Screening
Imaging:
9❑ X-ray 10❑ Bone Mineral Density 11❑ CT scan 12❑ Echocardiogram 13❑ Other Ultrasound 14❑ Mammography 15❑ MRI
Blood Tests:
16❑ CBC 17❑ Glucose 18❑ HgbA1c (glycohemoglobin) 19❑ Lipids/Cholesterol 20❑ PSA (Prostate specific antigen) 21❑ other

7. HEALTH EDUCATION Mark (x) all *ordered* or *provided* at this visit. 1❑ None 2❑ Asthma education
3❑ Diet/Nutrition 4❑Exercise 5❑ Family Planning/Contraception 6❑ Growth/Development 7❑ Injury Prevention
8❑ Stress Management 9❑Tobacco Use/exposure 10❑ Weight reduction 11❑ Other _____

8. VISIT DISPOSITION Mark (x) all that apply. 1❑ Refer to other physician 2❑ Return at specified time
3❑ refer to ER/Admit to hospital 4❑ Other_____