

IMPORTANT: Provider Please Review the Technician'/Nurse parts of the History (HPI,ROS,PFSH) and add to and/or change as appropriate. You must certify that this review has taken place in Statement of Note Agreement below:

Provider's Agreement with Support Staff Documentation

/ Provider agrees with Information Entered in this Encounter by Support Staff in the following Areas: Vital Signs, Screening, Chief Complaint, HPI, ROS and PFSH.



NOTE: DO NOT ERASE information in the free text boxes. If you see words or phrases, start typing after it. If you see a squiggly line(s) or no free text, begin typing in the upper left corner

Chief Complaint / History of Present Illness

Chief Complaint ~ ~

History of Present Illness (2000 Character Limit) -- Type <CTRL>+<ENTER> for new line --

Large empty text area for History of Present Illness with a vertical scrollbar on the right side.

Additional History Pain Severity /10 ~ ~

Past Medical / Surgical History and Medications

Medical History

Surgical History

Family History (1)

Current Medications

Empty text area for Medical History with a vertical scrollbar on the right side.

Empty text area for Surgical History with a vertical scrollbar on the right side.

Empty text area for Family History (1) with a vertical scrollbar on the right side.

Text area for Current Medications containing the text "MEDS REVIEWED AND RECONCILED" with a vertical scrollbar on the right side.

Vitamins/Herbals/OTCs

Vitamins Taking OTC Meds Dietary Supplements Herbal Meds Weight-Loss Meds

Social History

Reviewed Social History ~ ~

Tobacco

Never Used Tobacco Products Use ICD-9 Code 305.1 for current tobacco use. If counseled for 3-10 minutes use 2nd E&M Code 99406

Social History

Reviewed Social History

Tobacco

Never Used Tobacco Products [Use ICD-9 Code 305.1 for current tobacco use. If counseled for 3-10 minutes use 2nd E&M Code 99406](#)

Tobacco

Desire to Quit Smoking

Previous History of Smoking /Tobacco Use (pack-years)

Alcohol

No Alcohol / Don't Drink

Alcohol [If this box is clicked, ALL of the information below will appear in record](#)

Kind of Alcohol:	Amount:	How Often:
Have You Ever Felt You Should Cut Down On Your Drinking?	() Yes	() No
Have People Annoyed You By Criticizing or Complaining About Your Drinking?	() Yes	() No
Have You Ever Felt Bad or Guilty About Your Drinking?	() Yes	() No
Have You Ever Had a Drink (or Drug) in the Morning (Eye Opener) to Stead	es	() No

Exercise

Not Engaged in Routine Activity for Health Improvement

[If Yes, Please Answer the questions immediately below](#)

[Please Specify the Number of Minutes for the Appropriate Exercise in the Box to the Right of the Question. DO NOT ERASE THE FREE TEXT](#)

- Moderate Aerobic Activity (Like Walking) (Specify Amt of Time) ----->
- Vigorous Aerobic Activity (Like Running) (Specify Amt of Time) ----->
- Weightlifting / Strength Training (Specify Amt of Time) ----->

Female ONLY Data

Could You Be Pregnant Date of Last Period

Pregnant For ___ Weeks Based on LMP Presently Using Birth Control (Specify):

Military-Related Information

Branch of Service: US Army US Navy USAF USMC USCG Natl Guard

Status: Active Duty Reserve Now Deployed Retired

[For An Explanation of Each of the Following, Please See the HELP Tab on this Form](#)

Visit is Deployment-Related IF YES, please type in the Location of Deployment

Military-Related Information

Branch of Service: US Army US Navy USAF USMC USCG Natl Guard

Status: Active Duty Reserve Now Deployed Retired

For An Explanation of Each of the Following, Please See the HELP Tab on this Form

Visit is Deployment-Related ~ ~ ~ If YES, please type in the Location of Deployment

Visit is GWOT-Related ~ ~ ~ GWOT = Global War On Terrorism

Visit is PDHRA - Related ~ ~ ~ PDHRA = Post-Deployment Health Reassessment

Special Duty Related

PRP (Personnel Reliability Program) ~ ~ ~ PSP (Presidential Support Program)

SCI (Sensitive Compartmented Information Authorized) ~ ~ ~

Source of Medical Information

Information Source: Patient Other: ~ ~ ~ Reliability of source: ~ ~ ~

[Click to select the appropriate term ^^^](#)

Learning and Understanding

Learning Disability (Barriers to Learning) ~ ~ ~



Est. Patients - Quick 2 R05

All Normal (2)

- Fever R05
- Chills R05
- Nausea R05
- Vomiting R05

Constitutional R05

- AutoNeg**
- Fever R05
 - Chills R05
 - Night Sweats R05
 - Generalized Pain R05
 - Feeling Tired R05
 - Recent Weight Loss R05
 - Recent Wt Gain R05

Head Symptoms R05

- AutoNeg**
- Headache R05
 - Facial Pain R05
 - Sinus Pain R05

Eye Symptoms R05

- AutoNeg**
- Eyesight Problems R05
 - Eye Pain R05
 - Sensitivity to Light R05
 - Red Eyes R05
 - Problems R05
 - Seeing Double R05
 - Wears Glasses

Neck Symptoms R05

- AutoNeg**
- Pain R05
 - Swollen Glands R05

Endocrine Sxs R05

- AutoNeg**
- Temp Intolerance R05
 - Hot Flashes R05
 - Repro Health Concerns R05
 - Sexual Complaints R05
 - Excessive Thirst / Fluid Intake R05

Pulmonary Sxs R05

- AutoNeg**
- Cough R05
 - Wheezing R05
 - Difficulty breathing R05
 - Awakening with SOB R05
 - Orthopnea R05

Cardiovascular R05

- AutoNeg**
- Chest Pain R05
 - Palpitations R05
 - Easy Bleeding R05
 - Easy Bruising R05

Gastrointestinal R05

- AutoNeg**
- Yellow Skin or Eyes R05
 - Decrease in Appetite R05

Breast Sxs R05

- AutoNeg**
- Breast Pain R05
 - Breast Lump R05

Gyn Symptoms R05

- AutoNeg**
- Less Bleeding R05
 - Excessive Bleeding R05
 - Bleed Between Periods R05
 - Severe Menstrual Pain R05
 - Stress Incontinence R05
 - Pelvic Pain R05
 - Dyspareunia R05

Genitourinary R05

- AutoNeg**
- Dysuria R05
 - Urinary Frequency R05
 - Urinary Urgency R05
 - Blood in the Urine R05
 - Flank Pain R05
 - Urinary Loss of Control R05
 - Testicular Lump R05
 - Vaginal Discharge R05
 - Abn Urethral Discharge R05

Skin Symptoms R05

Musculoskeletal R05

- AutoNeg**
- Limb Pain R05
 - Limb Swelling R05
 - Joint Pain R05
 - Joint Swelling R05
 - Back Pain R05

Psychological R05

- AutoNeg**
- Anxiety R05
 - Depression R05
 - Sleep Disturbances R05
 - Anhedonia R05
 - Decreased Functioning Ability R05
 - Suicidal Thoughts R05
 - Homicidal Thoughts R05

Neurological Sx R05

- AutoNeg**
- Memory Problems R05
 - Lightheadedness R05
 - Fainting (syncope) R05
 - Vertigo R05
 - Sensory Disturbances R05
 - Motor Disturbances R05
 - Limb Weakness R05
 - Gait Abnormality R05

Quick Physical Exam Entry for Normal Findings

Vital Signs <input type="checkbox"/> ▾	Reviewed	<input checked="" type="radio"/> Temp <input type="checkbox"/>	<input checked="" type="radio"/> Pulse <input type="checkbox"/>	<input checked="" type="radio"/> Resp <input type="checkbox"/>	<input checked="" type="radio"/> Blood Pressure <input type="checkbox"/>
Gen Appearance <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N WD <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N WN <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N NAD <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Oriented x3 <input type="checkbox"/>
Eyes <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N PERRL <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Sclera <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Conjunctiva <input type="checkbox"/>	
ENT <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> A <input type="checkbox"/> N TMs <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Posterior Pharyngeal Wall <input type="checkbox"/>		
Neck <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Tenderness <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Thyroid <input type="checkbox"/>	Lymph Nodes Enlargement:	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Cervical <input type="checkbox"/>
				<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Submandibular <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Postauricular <input type="checkbox"/>
				<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Supraclavicular <input type="checkbox"/>	
Lungs <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N CTA <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Wheezing <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Rales <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Rhonchii <input type="checkbox"/>
Heart <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N RRR <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Murmur <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Rub <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Gallop <input type="checkbox"/>
		<input checked="" type="checkbox"/> A <input type="checkbox"/> N S1 <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N S2 <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N S3 <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N S4 <input type="checkbox"/>
Abdomen <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N NT <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N ND <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N BS Decreased <input type="checkbox"/>	
		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Mass <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Spleen <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Liver <input type="checkbox"/>	
Male Genitalia <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Penis <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Testes <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Prostate <input type="checkbox"/>	
Female Genitalia <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Ext. Genitalia <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Vagina <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Cervix <input type="checkbox"/>	
		<input checked="" type="checkbox"/> A <input type="checkbox"/> N Uterus <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Adnexae <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N CMT <input type="checkbox"/>	
Breasts <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Appearance <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Palpation <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Axillary Nodes Enlarged <input type="checkbox"/>	
Skin <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Lesions <input type="checkbox"/>	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Bruising <input type="checkbox"/>		
Neuro <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> A <input type="checkbox"/> N CN II-XII <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N DTRs <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Balance <input type="checkbox"/>	
		<input checked="" type="checkbox"/> A <input type="checkbox"/> N Gait / Stance <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Sensation <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Cerebellar <input type="checkbox"/>	
Psych <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Mood <input type="checkbox"/>	<input checked="" type="checkbox"/> A <input type="checkbox"/> N Affect <input type="checkbox"/>		
Extremities <input type="checkbox"/> ▾	Normal	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Edema <input type="checkbox"/>			

Other Physical Findings (limit 2000 chars)

/ Chaperoned by:

<p>Vital Signs <input type="checkbox"/></p> <p><input checked="" type="radio"/> T : Reviewed</p> <p><input checked="" type="radio"/> P : Reviewed</p> <p><input checked="" type="radio"/> R : Reviewed</p> <p><input checked="" type="radio"/> Blood Pressure : Reviewed</p>	<p>Neck <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> Exam of the Neck</p> <p><input type="checkbox"/> <input type="checkbox"/> Tender on Palpation</p> <p><input type="checkbox"/> <input type="checkbox"/> Decreased Suppleness</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid</p>	<p>Gastrointestinal <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> Mass</p> <p><input type="checkbox"/> <input type="checkbox"/> Diminished/Absent BS</p> <p><input type="checkbox"/> <input type="checkbox"/> Abdominal Tenderness</p> <p><input type="checkbox"/> <input type="checkbox"/> Muscle Guarding</p> <p><input type="checkbox"/> <input type="checkbox"/> Murphys Sign</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver</p> <p><input type="checkbox"/> <input type="checkbox"/> Abdominal Hernia</p> <p><input type="checkbox"/> <input type="checkbox"/> Perineum Exam</p> <p><input type="checkbox"/> <input type="checkbox"/> Rectum</p> <p><input type="checkbox"/> <input type="checkbox"/> Stool Sample for FOB</p>	<p>Lymph Nodes <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> Cervical</p> <p><input type="checkbox"/> <input type="checkbox"/> Submandibular</p> <p><input type="checkbox"/> <input type="checkbox"/> Supraclavicular</p> <p><input type="checkbox"/> <input type="checkbox"/> Axillary</p> <p><input type="checkbox"/> <input type="checkbox"/> Inguinal</p> <p><input type="checkbox"/> <input type="checkbox"/> Tender</p>	
<p>Constitutional <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> General Appearance</p> <p><input type="checkbox"/> <input type="checkbox"/> Well Developed</p> <p><input type="checkbox"/> <input type="checkbox"/> Well Nourished</p> <p><input type="checkbox"/> <input type="checkbox"/> No Acute Distress</p>	<p>Respiratory <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> Resp'n, Rhythm_Depth</p> <p><input type="checkbox"/> <input type="checkbox"/> Exag. Accessory Ms Use</p> <p><input type="checkbox"/> <input type="checkbox"/> Lungs Percussion</p> <p><input type="checkbox"/> <input type="checkbox"/> Vocal Fremitus</p> <p><input type="checkbox"/> <input type="checkbox"/> Auscultation</p> <p><input type="checkbox"/> <input type="checkbox"/> Wheezing Heard</p> <p><input type="checkbox"/> <input type="checkbox"/> Rales Heard</p> <p><input type="checkbox"/> <input type="checkbox"/> Rhonchii Heard</p>	<p>Male Genitourinary <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> Penis</p> <p><input type="checkbox"/> <input type="checkbox"/> Scrotum</p> <p><input type="checkbox"/> <input type="checkbox"/> Testes</p> <p><input type="checkbox"/> <input type="checkbox"/> Prostate</p>	<p>Musculoskeletal <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> Balance</p> <p><input type="checkbox"/> <input type="checkbox"/> Gait And Stance</p> <p><input type="checkbox"/> <input type="checkbox"/> Rombergs Sign</p> <p><input type="checkbox"/> <input type="checkbox"/> Coordination/Cerebellar</p>	
<p>Eyes <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> Conjunctiva</p> <p><input type="checkbox"/> <input type="checkbox"/> Sclera</p> <p><input type="checkbox"/> <input type="checkbox"/> Eyelids</p> <p><input type="checkbox"/> <input type="checkbox"/> Optic Disc</p> <p><input type="checkbox"/> <input type="checkbox"/> Retina</p> <p><input type="checkbox"/> <input type="checkbox"/> PERRL</p> <p><input type="checkbox"/> <input type="checkbox"/> Pupil Accommodation</p> <p><input type="checkbox"/> <input type="checkbox"/> Pupil Size</p>	<p>Breasts <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> Breast Appearance</p> <p><input type="checkbox"/> <input type="checkbox"/> Breast Palpation</p>	<p>Female Genitourinary <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> External Genitalia</p> <p><input type="checkbox"/> <input type="checkbox"/> Vagina</p> <p><input type="checkbox"/> <input type="checkbox"/> Cervix</p> <p><input type="checkbox"/> <input type="checkbox"/> Uterus</p> <p><input type="checkbox"/> <input type="checkbox"/> Uterine Adnexae</p> <p><input type="checkbox"/> <input type="checkbox"/> CMT</p>	<p>Neurological <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> CN II-XII</p> <p><input type="checkbox"/> <input type="checkbox"/> Sensation</p> <p><input type="checkbox"/> <input type="checkbox"/> Monofilament Test</p> <p><input type="checkbox"/> <input type="checkbox"/> DTRs</p>	
<p>ENT <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> Outer Ear</p> <p><input type="checkbox"/> <input type="checkbox"/> Ext. Nasal Deformity</p> <p><input type="checkbox"/> <input type="checkbox"/> Nasal Discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus Tenderness</p> <p><input type="checkbox"/> <input type="checkbox"/> Nasal Mucosa</p> <p><input type="checkbox"/> <input type="checkbox"/> Nasal Septum</p> <p><input type="checkbox"/> <input type="checkbox"/> Turbinate Swollen</p> <p><input type="checkbox"/> <input type="checkbox"/> Turbinate Frutheomatous</p>	<p>Cardiovascular <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> Thrill</p> <p><input type="checkbox"/> <input type="checkbox"/> Irregular Rate/Rhythm</p> <p><input type="checkbox"/> <input type="checkbox"/> Sounds <input type="text" value="S1 - S2:"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> S3 Heard</p> <p><input type="checkbox"/> <input type="checkbox"/> S4 Heard</p> <p><input type="checkbox"/> <input type="checkbox"/> Click Heard</p> <p><input type="checkbox"/> <input type="checkbox"/> Friction Rub</p> <p><input type="checkbox"/> <input type="checkbox"/> Murmurs</p> <p><input type="checkbox"/> <input type="checkbox"/> Carotid Bruit</p>	<p>Either Gender GU <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> CVA Tenderness</p>	<p>Psychiatric Exam <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> Judgment</p> <p><input type="checkbox"/> <input type="checkbox"/> MMS Exam <input type="text" value=": out of 30"/></p> <p><input type="checkbox"/> <input type="checkbox"/> Oriented x3</p> <p><input type="checkbox"/> <input type="checkbox"/> Recent memory impaired</p> <p><input type="checkbox"/> <input type="checkbox"/> Remote memory impaired</p> <p><input type="checkbox"/> <input type="checkbox"/> Mood</p> <p><input type="checkbox"/> <input type="checkbox"/> Affect</p>	
		<p>Skin <input type="text"/></p>		

Preventive Medicine for AFMS COMPASS AIM Form
Info gathered from U.S. Preventive Services Task Force (USPSTF) and Centers for Disease Control and Prevention (CDC)

To Access the latest Immunization and Screening Recommendations from the CDC and USPSTF - click the ? to the right

Screening Exams - Current USPSTF Recommendations ----->

Current Immunization Schedule All Ages - CDC Recommendations ----->

Preventive Medicine Services

History of preventive medicine services:

- » Fasting Blood Sugar --
- » Lipid Panel --
- » Electrocardiogram --
- » Colon Cancer Screen --
- » Aspirin Prophylaxis --

MALE Specific Screening: (if applicable)

- » PSA/Prostate Exam --
- » AAA Screen --

FEMALE Specific Screening: (if applicable)

- » Pap Smear --
- » Breast Cancer --
- » DEXA Scan --
- » Chlamydia Screening --
- » GC Screening --

Disease-Specific Monitoring

DIABETES MONITORING:

- » A1C --
- » Lipid Panel --
- » Microalbumin --
- » GFR --

Obesity:

Screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.

Lipids:

Screen men aged 35 or older for lipid disorders. Screen women 45 and older at increased risk for coronary heart disease (CHD). Screen men 20-34 and women 20-44 at increased risk for CHD

Diabetes Screening:

Screen for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) > 135/80 mm Hg every 3 years.

Aspirin Use:

Discuss risks and benefits of chemoprevention with adults at risk for coronary heart disease. Men >40 years | postmenopausal women and younger people with risk factors for coronary heart disease (eg, hypertension | diabetes or smoking) are at increased risk for heart disease and may wish to consider aspirin therapy.

Colorectal Cancer:

Screen for colon cancer using fecal occult blood testing, sigmoidoscopy or colonoscopy beginning at age 50 and continuing to age 75. Using any of the following 3 regimens will be approx. equally effective assuming 100% adherence to the same regimen for that period: 1) annual high-sensitivity fecal occult blood testing - 2) Sigmoidoscopy every 5 years and 3) Screening colonoscopy at 10-year intervals.

MALES

Testicular:

The USPSTF recommends against routine screening for testicular cancer in asymptomatic adolescent and adult males.

Prostate Cancer:

The USPSTF recommends against screening for prostate cancer in men age < 75. The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men < 75 years. A clinician should not order the PSA test without first discussing the potential but uncertain benefits and the known harms of prostate cancer screening and treatment.

Abdominal Aortic Aneurysm:

Perform 1 time ultrasonography for males age 65-75 who have ever smoked

FEMALES

not order the PSA test without first discussing the potential but uncertain benefits and the known harms of prostate cancer screening and treatment.

Disease-Specific Monitoring

DIABETES MONITORING:

- » A1C --
- » Lipid Panel --
- » Microalbumin --
- » GFR --
- » Eye Exam --
- » Foot Exam --
- » BMI --

OTHER (Specify):

Abdominal Aortic Aneurysm:

Perform 1 time ultrasonography for males age 65-75 who have ever smoked

FEMALES

Chlamydia:

Screen for chlamydial infection for all sexually active young women aged 24 and younger and for older women who are at increased risk.

Gonorrhea:

Screen all sexually active women for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors...)

Cervical Cancer:

Begin screening at age 21 or within 3 years of onset of sexual activity. Screen at least every 3 years. The USPSTF recommends against routinely screening women > 65 for cervical cancer if they have had adequate recent screening with normal Pap Smears and are not otherwise at high risk for cervical cancer

Breast Cancer:

Screen with mammography with or without clinical breast examination every 1-2 years for women age 40 and over

Osteoporosis:

Screen women age 65 and over with no risk factors. Begin screening at age 60 for women at increased risk for osteoporotic fractures

Immunizations

Reviewed and Current [~ ~]

<input checked="" type="checkbox"/> <input type="checkbox"/> Recently Received Flu Shot for Current Flu Season (Sep - April)	<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> Hepatitis A Up to Date
<input checked="" type="checkbox"/> <input type="checkbox"/> Received Pneumovax 23 Within Past 5 - 10 Years	<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> Hepatitis B Vaccine Series Up To Date
<input checked="" type="checkbox"/> <input type="checkbox"/> Td Vaccine Up to Date	<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> MMR Up To Date
<input checked="" type="checkbox"/> <input type="checkbox"/> Zoster Up to Date	<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> Varicella Up to Date
<input checked="" type="checkbox"/> <input type="checkbox"/> HPV Up to Date	<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> Meningococcal Immunization Up to Date

****NOTE**: An X Denotes Items that Must Be Documented for a Given Disease Process**

Indicator	Heart Failure / Acute MI	Hypertension	Asthma	Diabetes	Comments
<input type="checkbox"/> <input type="checkbox"/> Aspirin	X				
<input type="checkbox"/> <input type="checkbox"/> Antihypertensives Ace Inhibitors	X				
<input type="checkbox"/> <input type="checkbox"/> Smoking Cessation	X		X		- Advice / Counseling
<input type="checkbox"/> <input type="checkbox"/> Beta Blockers - Total Daily Dose	X				
<input type="checkbox"/> <input type="checkbox"/> Systolic BP 140 or Greater	X	X			
<input type="checkbox"/> <input type="checkbox"/> Systolic BP 130 - 139 MmHg	X	X			
<input type="checkbox"/> <input type="checkbox"/> Systolic BP Less Than 130	X	X		X	
<input type="checkbox"/> <input type="checkbox"/> Diastolic BP 90 or Greater	X	X			
<input type="checkbox"/> <input type="checkbox"/> Diastolic BP 80-89 MmHg	X	X			
<input type="checkbox"/> <input type="checkbox"/> Diastolic BP Less Than 80	X	X		X	
<input type="checkbox"/> <input type="checkbox"/> Evaluation of Left Ventricular Systolic Fxn	X				
<input type="checkbox"/> <input type="checkbox"/> Blood Pressure Control Meeting Goals		X			(BLOOD PRESSURE CONTROL MEETING GOALS)
<input type="checkbox"/> <input type="checkbox"/> Lifestyle Modifications		X			(LIFESTYLE MODIFICATIONS)
<input type="checkbox"/> <input type="checkbox"/> Patient Education - Action Plan Asthma			X		or Self Management Education for Patient with Persisten
<input type="checkbox"/> <input type="checkbox"/> Anti-inflammatory Inhaled / Nasal Steroids			X		FOR PERSISTENT ASTHMA
<input type="checkbox"/> <input type="checkbox"/> Spirometry Documented			X		FOR DIAGNOSIS OF ASTHMA
<input type="checkbox"/> <input type="checkbox"/> Peak Flow Meter			X		- DOCUMENTED
<input type="checkbox"/> <input type="checkbox"/> Pulse Oximetry			X		
<input type="checkbox"/> <input type="checkbox"/> Pneumococcal Vaccine			X		
<input type="checkbox"/> <input type="checkbox"/> Influenza Immunization			X		Up-to-Date

<input type="checkbox"/> <input type="checkbox"/> Influenza Immunization			X		Up-to-Date
<input type="checkbox"/> <input type="checkbox"/> Asthma			X		(SEVERITY LEVEL DOCUMENTED)
<input type="checkbox"/> <input type="checkbox"/> Asthma Mild Intermittent			X		
<input type="checkbox"/> <input type="checkbox"/> Asthma Mild Persistent			X		
<input type="checkbox"/> <input type="checkbox"/> Asthma Moderate Persistent			X		
<input type="checkbox"/> <input type="checkbox"/> Asthma Severe Persistent			X		
<input type="checkbox"/> <input type="checkbox"/> Documented and Reviewed				X	(YEARLY LDL)
<input type="checkbox"/> <input type="checkbox"/> LDL				X	(Management Test Value)^() LDL < 100 Meeting Goal
<input type="checkbox"/> <input type="checkbox"/> LDL < 100 Mg/dl				X	(MEETING GOALS)
<input type="checkbox"/> <input type="checkbox"/> Visual Assessment				X	(YEARLY EXAM FOR DIABETIC RETINOPATHY)
<input type="checkbox"/> <input type="checkbox"/> Comprehensive Eye Exam				X	
<input type="checkbox"/> <input type="checkbox"/> Recent Foot Exam by a Podiatrist				X	
<input type="checkbox"/> <input type="checkbox"/> Monofilament Test of the Foot Performed				X	
<input type="checkbox"/> <input type="checkbox"/> Arterial Pulses Normal				X	
<input type="checkbox"/> <input type="checkbox"/> Hair on the Feet Absent				X	
<input type="checkbox"/> <input type="checkbox"/> Skin Exam Done				X	
<input type="checkbox"/> <input type="checkbox"/> Urine Protein (0-4+)				X	
<input type="checkbox"/> <input type="checkbox"/> Hemoglobin A1C				X	