PREVENTIVE CARE

Adult annual physical

Blank documentation outlines. Adapt to the encounter and your practice requirements; complete only findings and care actually documented.

ENCOUNTER

Patient name:

Date of birth:

Date and time of encounter:

Clinician:

INTERVAL HISTORY

Patient concerns and goals for the visit

Changes in health, hospital or specialist care since last visit

Current medications, supplements and allergies reviewed

Family history updates

RISK REVIEW

Tobacco, alcohol and substance use as reported

Physical activity, diet and sleep as reported

Depression screening tool and result if performed

Other screening questionnaires and results

PREVENTIVE SERVICES

Screenings completed, with dates and sources

Screenings due or overdue and decisions made

Immunizations reviewed, given today or declined

EXAMINATION

Vitals measured today, with units

Examination performed and findings

ASSESSMENT AND PLAN

Preventive recommendations and patient decisions

Problems addressed today, documented separately

Orders and referrals

Counseling provided

FOLLOW-UP

Follow-up timing and purpose

Return precautions discussed

Patient questions and understanding