FAMILY MEDICINE

Chronic condition follow-up

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

Conditions addressed today

Changes since the previous visit

Patient priorities and functional impact

Medication use, response, adverse effects and access barriers

FINDINGS

Home readings with dates, source and units

Vitals measured today, with units

Relevant examination findings

Results reviewed with dates

PROBLEM-BASED ASSESSMENT AND PLAN

Condition and current status

Evidence supporting the assessment

Treatment decisions and rationale

Monitoring, orders and agreed goals

FOLLOW-UP

Follow-up timing and purpose

Return precautions discussed

Patient questions and understanding