FAMILY MEDICINE

New patient visit

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:

VISIT PRIORITIES

Patient concerns and goals

Current symptoms and relevant timeline

HISTORY

Medical and surgical history

Family history

Social history and relevant exposures

Current medications, doses as reported and reconciliation

Allergies and reactions

Preventive care records reviewed and dates

EXAMINATION

Vitals measured today, with units

Examination performed and findings

ASSESSMENT AND PLAN

Each problem addressed and supporting findings

Diagnostic or treatment decisions

Preventive services discussed

Records requested and responsibility for follow-up

FOLLOW-UP

Follow-up timing and purpose

Return precautions discussed

Patient questions and understanding