Patient Name:	HealthCare Partners, IPA HealthCare Partners, MSO
D.O.B.: _____ / _____ / _____	PROVIDER NAME & CREDENTIALS OR OFFICE STAMP:
Date of Service: _____ / _____ / 20____	

CHIEF COMPLAINT/HPI:

PAST MEDICAL HISTORY:

VITALS

BP: /	PULSE:	RESP:	TEMP:	HEIGHT:	WEIGHT:	BMI:
ALLERGIES:					PAIN SCALE:	

PHYSICAL EXAM

	WNL	ABN
HEENT		
NECK		
CHEST		
BREAST		
HEART		
ABDOM		
PELVIC		
RECTAL		
EXTREM		
NEURO		
SKIN		
EKG		
PFT		

MEDICATIONS

Medications initialed below have been reviewed on DOS	ASSOCIATED DIAGNOSIS	INITIAL
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		

PREVENTIVE HEALTH CARE

☐ **Breast Cancer Screening (BCS):**
DOS: _____ / _____ / 20____

☐ **Colorectal Cancer Screening (COL):**
DOS: _____ / _____ / 20____

☐ **Bone Mineral Density testing**
DOS: _____ / _____ / 20____

For **DIABETIC** patients please check if the test below have been performed during the current calendar year.

☐ **HbA1c**
DOS: _____ / _____ / 20____
Result: _____

☐ **Nephro**
(Urine test: i.e. Urinalysis, Microalbumin)
Specify test: _____

☐ **Diabetic Eye Exam**
performed by Eye Care Professional
DOS: _____ / _____ / 20____

Patient Name:

D.O.B.: _____ / _____ / _____

Date of Service: _____ / _____ / 20____

HealthCare Partners, IPA
HealthCare Partners, MSO

PROVIDER NAME & CREDENTIALS OR OFFICE STAMP:

DIAGNOSIS:	STATUS:	PLAN:
Include stage, severity and link diagnosis when required	*Circle one:*	
1	STABLE WORSENIING IMPROVING	
2	STABLE WORSENIING IMPROVING	
3	STABLE WORSENIING IMPROVING	
4	STABLE WORSENIING IMPROVING	
5	STABLE WORSENIING IMPROVING	
6	STABLE WORSENIING IMPROVING	
7	STABLE WORSENIING IMPROVING	
8	STABLE WORSENIING IMPROVING	
9	STABLE WORSENIING IMPROVING	
10	STABLE WORSENIING IMPROVING	
11	STABLE WORSENIING IMPROVING	
12	STABLE WORSENIING IMPROVING	

ADDITIONAL INFORMATION / IMPRESSION / PLAN / HEALTH EDUCATION / REFERRALS

SIGNATURE

Please circle ***CREDENTIAL*** **MD DO PA NP**