

NYU Faculty Group Practice
 Consultation/Office Visit Template

Patient Name: _____	Date of Birth: _____
Date of Visit: _____	Physician requesting (if applicable) _____

Chief Complaint: _____

Vital Signs:

Ht: _____ Wt: _____ Pulse: _____

Allergies: ___ NKA

BP: _____ / _____ T: _____ P: _____ RR: _____

Current Medications: none See list

History of Present Illness: <small>Brief = 1-3 Extended = 4+</small>	Review of Systems: <small>Check mark = NL Circle Positives, X for Negative Note Findings</small>
<p>Location:</p> <p>Quality:</p> <p>Assoc. Signs/Symptoms:</p> <p>Modifying Factors:</p> <p>Context:</p> <p>Onset/Timing:</p> <p>Duration:</p> <p>Severity:</p> <p>Prior Episodes:</p> <p>Hx obtained from:</p>	<div style="text-align: right; font-size: small; margin-bottom: 10px;"> Problem Pertinent = 1 Extended = 2-9 Complete = 10+ </div> <p><input type="checkbox"/> Constitutional:</p> <p><input type="checkbox"/> Respiratory:</p> <p><input type="checkbox"/> Cardiovascular:</p> <p><input type="checkbox"/> ENMT:</p> <p><input type="checkbox"/> Gastrointestinal:</p> <p><input type="checkbox"/> Genitourinary:</p> <p><input type="checkbox"/> Psychiatric:</p> <p><input type="checkbox"/> Neurological:</p> <p><input type="checkbox"/> Integumentary:</p> <p><input type="checkbox"/> Musculoskeletal:</p> <p><input type="checkbox"/> Endocrine:</p> <p><input type="checkbox"/> Hematologic/Lymphatic:</p> <p style="margin-left: 20px;">Childhood Immunizations: __ Y __ N</p> <p><input type="checkbox"/> Allergic/Immunologic:</p> <p><input type="checkbox"/> All other systems normal</p> <p>Past Medical, Family & Social HX</p> <div style="text-align: right; font-size: x-small; margin-top: 10px;"> Pertinent = 1 Complete = 2 </div> <p>Previous Trauma:</p> <p>Surgeries/Procedures:</p> <p>Family Hx: (CA, HTN, CVA, DM, CV, SZ)</p> <p>Previous Illnesses/Hospitalizations:</p> <p>Social Hx: Tobacco ___ EtOH ___ Drugs _____</p> <p>Lives alone/with _____</p>

