DATE: _____/_____/_____ CONSULTATION FORM **ROBERT W. HERRING, Jr., M.D.**

Last Name	First	Name We Should Call You	Middle	If No Middle Name Check Here ____

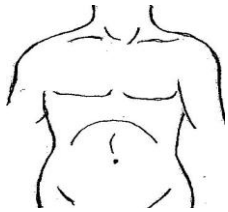
Physician Who Referred You: _____ None _____
Family or Main Physician: _____ None _____
Other non-physician who referred you: _____

Birth Date ____/____/____ Age

Chief Complaint: What is the main reason you are here today? _____Have you had any recent x-rays pertaining to the reason you are here today? yes _____ no _____
Comments: _____
Have you had any recent lab pertaining to the reason you are here today? yes _____ no _____
Comments: _____
Initials of Nurse who called for results of above lab and x-rays or verified none available: _____

DO YOU HAVE A PROBLEM WITH ANY OF THESE NOW? PLEASE CHECK THE APPROPRIATE BOX

PRESENT ILLNESS	YES	NO	COMMENTS
Heartburn (pyrosis)			If yes, on how many days per week?_____
Undigested food comes into mouth?			If yes, on how many days per week?_____
Difficulty swallowing (dysphagia)			If yes, are you having difficulty with: solids ____ liquids ____ both ____
Painful swallowing (odynophagia)			If yes, where is the pain:_____
Get full too early (early satiety)			
Weight loss			If yes, how many pounds: _____ over how many months: _____
Nausea			How many days per week: _____
Vomiting			How many days per week: _____
Vomiting blood (hematemesis)			If yes, how much: _____
Abdominal Pain			If yes, mark location on diagram. ⟶
Bloating			If yes, does your tummy actually puff out? _____
Excessive Gas (eructation/flatulence)			If yes, do you have: belching _____ rectal gas _____
Diarrhea			If yes, specify number of stools per day: _____
Bowel Urgency			Have you had a sudden, unexpected need to have a BM? yes____ no____
Fever			If yes, what was your highest temperature? _____
Black loose stools (melena)			If yes, when was last time it happened? _____
Low Blood Count (anemia)			If yes, month and year that last blood count measured: ____/____
Rectal bleeding (hematochezia)			If yes, how much blood each time? _____
Constipation			If yes, specify number of days without a bowel movement: _____
Do you have anal pain with bowel movements? (dyschezia)			If yes, when was last time it happened: _____
Do any foods make symptoms worse? (food intolerance)			If yes, which foods make which symptoms worse? _____ _____
Does milk cause rectal gas/diarrhea?			
Yellow skin (jaundice)			



PRESENT ILLNESS: This box is for M.D. use only. Do not fill in the blanks. Need 4 elements for level 3, 4 or 5 encounter.

Symptom: _____

Onset: ____ Unknown _____

Location: ____ not applicable to symptom _____

Quality: _____ patient cannot describe _____

Radiation (Cannot count as element):___ not applicable to symptom _____

Duration (Cannot count as element): ___ not applicable to symptom _____

Severity: _____

Timing:____ Symptoms did not occur at any particular time of day _____

Context:____ Symptoms did not occur in the context of any particular activity _____

Modifying Factors: _____ No modifying factors were identified. _____

Associated Symptoms: _____ No associated symptoms were identified. _____

DO YOU USE ANY OF THE FOLLOWING? (CHECK THE APPROPRIATE BOX)

SOCIAL HISTORY	YES	NO	COMMENTS		
Alcohol					
Cigarettes					
Caffeine/Colas			cups/day ____	glasses/day ____	
Have you had oral, anal, or vaginal sex with a member of the **SAME** sex in the last ten years?			Honest answers to the questions in this section will allow our doctors to order additional tests that would not otherwise be ordered to diagnose your problem.		
Have you ever been physically or sexually abused?			_____ Physical _____ Sexual	Is abuse continuing? ____ yes ____ no	
Have you had recent travel outside the United States?			Where: _____ When: Year: _____ Month(s): _____ Day(s): _____		

Describe Your Job _____	Race _____ Check if Latino □	Sex		Marital Status					Number of Dependents
Check if you are: Retired ___ Homemaker ___ Unemployed ___		M	F	S	M	W	D	Separated	

STRESS: **Level of personal/family stress** - score 0 to 10 (10 being the highest level)_____

Level of stress on job - score 0 to 10 (10 being the highest level) _____

Number of years of schooling: _____

Medications, allergies and past medical history are found in the problem list.

FAMILY HISTORY:

Health status of mother: _____ If deceased, cause of death: _____

Health status of father: _____ If deceased, cause of death: _____

Health status of brothers or sisters:_____ If deceased, cause of death: _____

Health status of children: _____ If deceased, cause of death: _____

CHECK APPROPRIATE BOX IF YOUR IMMEDIATE FAMILY HAD ONE OF THE CONDITIONS BELOW. Immediate family refers to blood relatives only, not relatives by marriage. This does **NOT** apply to **YOU**, yourself.

DISEASE	YES	NO	WHO	DISEASE	YES	NO	WHO	DISEASE	YES	NO	WHO
Liver disease				Spastic colon (irritable bowel)				Cancer of Colon			
_ Ulcerative Colitis				Pancreatitis				Colon polyps			
Crohn's Disease				Anesthesia Complications				If yes, describe anesthesia complications:			

PROBLEM LIST

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THE APPROPRIATE BOX.

PAST HISTORY/ REVIEW OF SYSTEMS/ MEDICAL ILLNESSES	**YES**	**NO**	**MEDICAL ILLNESSES**	**YES**	**NO**	**MEDICAL ILLNESSES**	**YES**	**NO**
Damage or artificial heart valve			Have you ever had ulcers?			Narrow urine stream today		
Shortness of breath			Seizure Disorder			Diabetes		
Chest Pain			Fast heart beat requiring medication			Anesthesia Complications: (explain below)		
Hemophilia, Von Willebrand's disease or similar illnesses			Liver Problems			Dentures or Loose Teeth		
Kidney Failure			Hepatitis			Breast Cancer		
Heart Blockage			Eye Pain			Asthma		
Are you on blood thinners now?			Blood Transfusions			Emphysema		
Sleep Apnea diagnosed in a sleep lab			High Blood Pressure			Bronchitis		
Heart Attack			Paralysis			Pneumonia		
Congestive Heart Failure			Sickle Cell			Multiple Sclerosis or Muscular Dystrophy		

Do you have any other medical problems or conditions? **DO NOT INCLUDE SURGERIES**			**NO SURGERIES HERE** 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____	**YEAR DONE**	**ENTRY DATE**
HAVE YOU HAD ANY SURGERIES?	**YES**	**NO**	**SURGERIES HERE:**	**YEAR DONE**	**ENTRY DATE**
Have you had any serious injury, procedure, or surgery in your life? **DO NOT WRITE IN ENTRY DATE COLUMN AREA**			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____		
Are you behind on your immunizations?	**YES**	**NO**	If yes, which ones?		
ALLERGIES	**YES**	**NO**	If yes, please list below: **DO NOT WRITE IN ENTRY DATE COLUMN**		
Do you have Any medication allergies?			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ **ENTRY DATE** 6. _____ 7. _____ 8. _____ 9. _____ 10. _____		

MEDICATION LIST

Name of prescription medications taken at home in last 30 days. If none place "X" HERE _____	Tablet size in milligram	# Tablets taken at a time	How many times taken daily	Entry date	Date medication discontinued	
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

Names of over-the-counter medications taken at home in last 30 days If none, place "X" HERE _____	Tablet size in milligram	# Tablets taken at a time	How many times taken daily	Entry date	Date medication discontinued	
1.						
2.						
3.						
4.						
5.						

IN THE LAST MONTH, HAVE YOU TAKEN ASPIRIN OR ASPIRIN-LIKE DRUGS SUCH AS IBUPROFEN, NUPRIN, ADVIL, ALEVE, ALKA-SELTZER, GOODY POWDERS, ETC.? IF YES, LIST ABOVE.	YES	NO

Pharmacy Name _____ **Phone #:** _____

DO YOU HAVE ANY OF THE FOLLOWING? PLEASE CHECK THE APPROPRIATE BOX

REVIEW OF SYSTEMS (Continued)	YES	NO		YES	NO
Nervousness/anxiety			Rashes		
Depression			Itching		
Difficulty sleeping			Food allergies		
Frequent headaches			Painful urination		
Trouble with memory			Blood in urine		
Trouble with coordination			Menstrual irregularities		
Arm or leg weakness			Pain with sex		
Arthritis			Do you think you might be pregnant?		
Sore throat			Do you have menstrual periods?		
			What was the date of your last period? (Be as exact as you can) _____	N/A	N/A
Migraine Headaches			Pneumonia		
Asthma			Flu		
High Blood Pressure			Took flu shot		
Previous Stroke			Sinus infection		
Varicose Veins			Colds (rhinovirus)		
High Cholesterol			Otitis media/ear infection		
Previous Heart Attack			Kidney stones		
Hepatitis A			Kidney infections		
Hepatitis B			Bladder infections		
Hepatitis C			Gallstones		
Alcoholic Hepatitis			Urinary incontinence		
Cirrhosis			Dry Eyes		
Alcoholic Cirrhosis			Obesity		
Are you on insulin?			Nutritional Deficiency What type: _____		
Pancreatitis			Endometriosis		

REMAINDER OF FORM TO BE COMPLETED BY PHYSICIAN.
PHYSICAL EXAMINATION GUIDELINES

1.COMPREHENSIVE EXAM: The upper two CPT code levels of any category of initial patient encounter require documentation of a comprehensive physical examination. These levels include 1) The office or other outpatient new patient visits (99204, 99205), 2) The office or other outpatient consultations (99244, 99245) 3) The initial hospital care encounters, i.e. the hospital history and physicals (99222, 99223) 4) The initial observation care encounters (99219, 99220). 5) The inpatient consultation (99254) 6) All 99255. There are no nursing facility care encounters which require a comprehensive exam. The comprehensive exam requires performance of all elements in nine systems and that two elements per system be documented. An element is noted by an asterisk in the physical exam below.
2.DETAILED EXAM: A detailed physical exam is required for 1) a level 3 office or other outpatient new patient visit (99230) 2) A level 3 new office consultation (99243) 3) A level 3 new hospital consultation (99253) 4) A level 1 initial hospital care encounter, i.e. hospital history and physical (99221) 5) An initial observation care encounter (99218). 6) A level 3 nursing facility care encounter (99313) requires that twelve elements in at least two systems be examined and documented.
3.EXPANDED PROBLEM FOCUSED EXAM: An expanded problem focused physical exam is required for 1) A level 2 new patient office or other outpatient visit (99202) 2) A level 2 office or other outpatient consultation (99242) 3) A level 2 hospital consultation and 4) A level 2 nursing facility care encounter (99312) Documentation of six elements is required.
4.PROBLEM FOCUSED EXAM: A problem focused physical exam is required for 1) A level 1 office or other outpatient new patient visit (99201) 2) A level 1 office or other outpatient consultation (99241) 3) A level 1 hospital consultation (99251) and a level 1 nursing facility use encounter (99311). Documentation of one element is required.

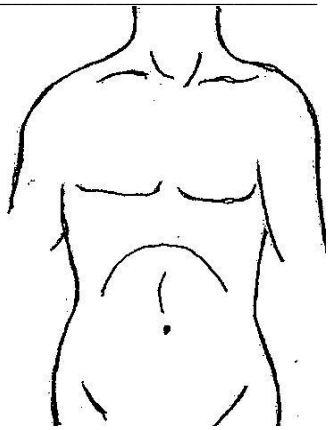
PHYSICAL EXAMINATION: The physician should amend the physical exam to reflect the individual patient's findings and check boxes as appropriate.

DECISION COMPLEXITY CHECKLIST (Need 2 of 3 to meet criteria for highest level encounter)

1. **ACCESSORY CLINICAL DATA**: The patient's medical records were requested for later review. After the review these records will be filed in the chart. Medical records received while the patient was present were reviewed and then filed in the chart.
   ___ The data reviewed or requested for later review are extensive.

2. **RISK ASSESSMENT**
   ___ The patient is at high risk for complications, morbidity or mortality for the reason checked below:
   ___ Sedation Risk: The anesthesia class is greater than I, i.e., the patient is at increased risk for undergoing sedation.
   ___ Procedure Risk: The patient is at increased risk for procedure complications.
   ___ Therapeutic Endoscopy: An endoscopy with therapeutic intent has been ordered.
   ___ Illness Exacerbation: The patient has a serious exacerbation of a chronic illness.
   ___ Treatment Side Effects: The patient has a severe side effect of treatment.
   ___ Other _____

3. **NUMBER OF DIAGNOSES AND MANAGEMENT OPTIONS** (Need 4 for highest encounter level and 3 for next highest level)

CONSTITUTIONAL (1) **(Need 3 vital signs)**	*** Mandatory VS: WT: _____ HT: _____ BMI: _____ R: _____ Pulse: _____ Check box if pulse irregular ☐ _____** **Optional VS: Lying BP-P _____/_____ - _____ Standing BP-P _____/_____ - _____ T: _____**
APPEARANCE **(part of constitutional- counts as one bullet)**	**☐ Except as noted, there was no change in the patient's interval history and physical exam since the last complete recorded history and physical, including the problem list and medication list.** **☐ Well developed person with: _____** **☐ Body habitus: _____** **O Average O Obese**
ENMT (2)	**☐ Ears: external ears and otoscopic inspection are normal. _____** **☐ Hearing: hearing is grossly intact. _____** **☐ Nose: the nose and nasal mucosa are normal. _____** **☐ Mouth: lips, teeth, and gums are grossly normal. _____** **☐ Throat: the throat is clear. _____**
NECK (3)	**☐ Neck: the neck is normal in overall appearance, symmetry, and tracheal position. _____** **☐ Lymphatic: there is no cervical adenopathy. _____** **☐ Thyroid: the thyroid is normal without enlargement or tenderness. _____** **☐ Carotid arteries: the carotid arteries are normal. _____**
RESPIRATORY (4)	**☐ Respiratory effort: respiratory effort is normal without accessory muscle usage. _____** **☐ Palpation: palpation of chest is normal without tactile fremitus. _____** **☐ Percussion: percussion of the chest is normal without dullness or hyperresonance. _____** **☐ Auscultation: auscultation of the lungs is normal with normal breath sounds. _____**
CARDIOVASCULAR (5)	**☐ Heart palpation: palpation of the heart is normal without thrills. _____** **☐ Heart auscultation: auscultation of the heart is normal with normal heart sounds and without murmur, gallop, or rub. _____**
IF TENDERNESS IS PRESENT, NOTE THE LOCATION ON THE DIAGRAM **ABDOMEN (6) (Auscultation and hemoccult not required)**	**☐ Bowel sounds: bowel sounds are normal. (not a bullet) _____** **☐ Tenderness: there is no tenderness. _____** **☐ Abdominal aorta: the abdominal aorta is normal without bruit. _____** **☐ Liver and spleen: there is no hepatosplenomegaly. _____** **☐ Hernia: there are no hernias present. _____** **☐ Femoral arteries: the femoral arteries are normal. _____** **☐ Lymphatic: there is no inguinal adenopathy. _____** **☐ Rectal: (when indicated)** **O The perineum is normal. _____** **O The anus is normal. _____** **O The rectum is normal without masses. _____** **O The stool is brown and:** **O hemoccult <u>negative</u> with a positive control. _____** **O hemoccult <u>positive</u> with a positive control. _____** 
SKIN (8)	**☐ Inspection: inspection is normal without rashes. _____** **☐ Palpation: palpation is normal without induration. _____**
PSYCHIATRIC (9)	**☐ Judgment and insight: Judgment and insight are normal. _____** **☐ Orientation: Orientation is normal. _____** **☐ Memory: Memory is normal. _____** **☐ Mood and affect: Mood and affect are normal. _____**
MUSCULOSKELETAL	**☐ Extremities: the extremities are without edema or gross deformity. _____** **☐ Pedal pulses: the pedal pulses are normal. _____**
NEUROLOGIC (H) **(H) = Hospital H&Ps only**	**☐ Cranial nerves: _____** **☐ Peripheral sensation: _____** **☐ Deep tendon reflexes: _____**
LYMPHATIC (7)	**See neck and abdomen.**
EYES	**Ophthalmoscopic exam required for comprehensive exam.**
GENITOURINARY	**Pelvic required for comprehensive exam.**

IMPRESSION (Diagnoses)
1.
2.
3.
4.
5.
6.

PLAN: (Management Options)
1.
2.
3.

Anesthesia Class of Physical Status: _____. Class I: No systemic illness. Class II: Mild to moderately severe systemic illness. Class III: Severe systemic illness. Class IV: Life-threatening illness. Class V: Moribund patient

Anesthesia Plan: The patient will be sedated with one or more sedative agents such that protective reflexes are maintained. A preoperative oral dose of a barbiturate and/or benzodiazepine may be given. **Informed Consent:** The nature, alternatives, indications, risks, and plan for conscious sedation and the above procedure(s) were discussed with the patient and/or guardian and questions were answered. The patient and/or guardian verbalized an understanding and agreed to undergo the procedure.

Signature: _____

Initials of Nurse Verifying Completeness of H&P _____