Physician Documentation/Dictation Template for Patient Visit
Example

If you did it – document it
If you thought it – record it

DEMOGRAPHICS

Patient Name  New Patient or Established Patient
Patient Age   Site of Service
Day, Time and Date of Service  Historian (patient or other)
Consultation Identify physician or non-physician Practitioner performing service

SUBJECTIVE INFORMATION

Chief Complaint or reason for the encounter

Asymptomatic/routine physical/annual visit/preventative visit

HPI: symptoms/complaints:
(location; quality or sensation; severity; duration of complaints onset to present; timing pattern frequency; context; modifying factors; associated signs and symptoms)

ROS: Indicate negative or positive findings. If all systems inventoried, note the negatives and positives for the presenting problems and include a statement “all other systems negative.”
(constitutional; ENMT; respiratory; genitourinary; integumentary; psychiatric; hematology/lymphatic; eyes; cardiovascular; gastrointestinal; musculoskeletal; neurologic; endocrine; allergy/immunological)

PFSH: Note the patient’s PFSH when appropriate, include immunization status, allergies, current medications and sexual activity (age appropriate). Include past surgeries, education and social habits.

OBJECTIVE EXAM

Document all systems/body areas examined and medically necessary

Constitutional: vitals, general appearance, etc.
**Eyes:** ocular motility, conjunctiva and lids, optic discs, posterior anterior segments, pupils and irises, appearance

**ENMT:** nasal mucosa, septum and turbinates, teeth and gums, oropharynx (palates, tongue, tonsils, and posterior pharynx), ears/otoscopic exam, assessment of hearing, tympanic membrane, external appearance

**Cardiovascular:** palpation of heart, auscultation of heart, carotid arteries, abdominal aorta, femoral arteries, pedal pulses, extremities for edema/varicosities, exam of peripheral vascular system, murmurs

**Respiratory:** inspection of chest with mention of symmetry and expansion, assessment of respiratory effort, percussion of chest, palpation of chest, auscultation of lungs

**Gastrointestinal:** examination of abdomen, examination of liver/spleen, examination for presence of hernia, examination of rectum, anus and perineum, including sphincter tone, hemorrhoids, etc, stool sample for blood (when indicated)

**Genitourinary:** as appropriate, (male) examination of scrotal contents, tenderness of cord, testicular mass, penis, digital rectal exam of prostate, epididymides, urethral meatus, sphincter tone, (female) pelvic examination, external genitalia, urethra, bladder, cervix, uterus, adnexa

**Musculoskeletal:** gait and station, digits and nails, joints, bones, muscles of the head, neck, spine, ribs and pelvis and each extremity, percussion or palpation, range of motion, stability or luxation, abnormal movements (specify site)

**Skin:** inspection or palpation, scars, rashes, lesions, tenderness, masses, ulcers, palpation of scalp, inspection of hair of scalp, susceptibility to or the presence of photo damage (site), inspection eccrine glands and apocrine glands of the skin, location of any hypehydrosis, chromhidrosis, or bomhidrosis, palpation of skin and sub-cu tissue

**Neurologic:** cranial nerves (specify) noting any deficits, deep tendon reflexes, examination of sensation and method used, evaluation of higher intergrative functions, coordination, and memory

**Psychiatric:** description of speech, description of thought process, description of associations, description of abnormal or psychotic thoughts, delusions, preoccupation with violence, homicidal or suicidal thoughts, obsessions, description of patient’s judgement, mental status examination, mood and affect, fund of knowledge, orientation

**Hematology/lymphatic/immunological:** palpation of lymph nodes (site)

**Body Areas:** dictate/document each body area examined: head/face, neck, chest (breast/axilla), abdomen, genitalia (groin/buttocks), back including the spine and each extremity

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**ASSESSMENT AND PLAN**

Medical Decision Making – putting your grey matter (brain assessment and plan) to the white matter (paper)

Tests ordered or reviewed, and the reason for all tests ordered
Medications managed/ordered/stopped/changed, IV therapy
Risk factors
Status of new problems or established problems
Invasive procedures planned or performed (document risk)
Diagnostic or therapeutic procedures performed (document reason performed)
Patient/family education
Review of old records or decision to obtain past records
Special instructions and follow-up care (referrals, consults, etc)
Diagnosis, working, definitive, changes in treatment and patient’s response
Hospital or observation admission or transfer out of facility

TIME

If rendering critical care, dictate/document the total time spent caring for the patient (bedside/unit per day; or other site)
If more than 50% of the visit was spend in counseling and/or coordination of care, dictate/document total time and counseling time with details
If patient visit was prolonged, dictate/document time and circumstance