

Sample History and Physical Note

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Chief Complaint (1/1): This 1 year-old female presents today for a health maintenance exam.

Patient was accompanied by mother.

The child eats 3 meals a day plus 2 snacks and is off the bottle.

Gabriella sleeps through the night. Gabriella takes morning and afternoon naps.

Mother is concerned about child's red, matted eye and not walking completely alone yet.

Immunizations need to be updated at today's visit.

Developmental milestones: 1 year developmental milestones reached: bangs blocks together, drinks from cup, eating finger foods, feeds self, gives toys on request, imitates vocalizations, looks for dropped or hidden objects, points to desired objects, pulls to stand and cruises, releases cube into cup after demonstration, says "mama" and "dada" with meaning, says one or two other words, tries to build tower of 2 cubes and waves bye.

Allergies: No known medical allergies.

Medications: None.

PMH: Past medical history is unremarkable.

PSH: No previous surgeries.

Family History: Patient admits a family history of cancer associated with maternal aunt, hypertension associated with paternal grandfather.

Social History: She lives at home with parents. Patient admits being in daycare.

Review of Systems: No change since last visit

Physical Exam: Temp: 97.6 Height: 0 ft. 31 in. Weight: 28 lbs. BMI: 20

Growth Chart Entry: Weight: 28 lbs 0 ozs Height: 0 ft 31 in Head Circumference: 18.50 in

Patient is a 1 year-old female who appears in no apparent distress, well developed and well nourished.

Inspection of head and face shows anterior fontanel normal, posterior fontanel normal and head is normocephalic and atraumatic.

Eyes: Fundoscopic exam reveals red reflex is present bilaterally.

Alignment is normal.

Sclera is white bilaterally.

Left inferior palpebral conjunctiva reveals conjunctivitis.

Ocular motility exam reveals gross orthotropia with full ductions and versions bilateral.

ENT: Pinna: normal.

Otoscopic examination reveals no abnormalities of external auditory canals and tympanic membranes.

Inspection of nose reveals no abnormalities and nares that are normal.

Nasal mucosa moist, pink, and without mass or exudate with no abnormalities of the septum and turbinates noted.

Inspection of lips, gums, and palate reveals no abnormalities.

Examination of oropharynx reveals no abnormalities and tissues pink and moist.

Neck: Neck exam reveals no masses.

Respiratory: Assessment of respiratory effort reveals even and nonlabored respirations.

Auscultation of lungs reveal clear lung fields and no rales noted.

Cardiovascular: Heart auscultation reveals rate is regular, rhythm is regular and no murmurs, gallop, rales or clicks.

Femoral pulses are 2 /4, bilateral.

Abdomen: Abdomen soft, non-tender, bowel sounds present x 4 without palpable masses.

Palpation of liver reveals no abnormalities.

Palpation of spleen reveals no abnormalities.

Genitourinary:

Examination of anus and perineum shows no abnormalities.

Musculoskeletal:

Inspection and palpation of bones, joints and muscles is unremarkable.

Muscle tone is normal.

Skin: Skin is not pale, jaundice, or cyanotic. Skin turgor, hydration, and texture is good.

Palpation of skin shows no abnormalities.

Neurologic/Psychiatric: Moves all extremities.

Test & X-Ray Results:

Hb: 12 g/dl.

Impression: Routine well child care.

Acute conjunctivitis.

Plan: Diagnostic & Lab Orders: Ordered blood lead.

Immunizations Given:

Varicella Type: IM Manufacturer: ABC Drug Co Lot: abc123 administered on 07/30/2003 by Ped, Nurse in the thigh, left.

Anticipatory Guidance for the 1 year old: Guidance given for injury and illness prevention: keep home and car smoke, drug, and alcohol free, avoid or limit TV viewing, use safety seat in back seat; can face forward, check home for lead hazards, supervise near water, empty tubs, buckets, pools, supervise near pets, mowers, driveways, streets and limit sun; use sunscreen and hat.

Guidance on nutrition provided including: provide 3 nutritious meals, 2-3 healthy snacks daily and allow child to feed self, use cup.

Discussed oral health.

Guidance provided on social competence including: praise good behavior, talk, sing, read together, encourage safe exploration, set limits (i.e. use distraction), don't allow hitting, biting, aggressive behavior, delay toilet training and expect curiosity about genitals.

Discussed parent-infant interaction and family relationships.

Return to office in 3 month(s).

Patient Instructions:

Patient given information on conjunctivitis

Prescriptions:

Tobramycin ophthalmic Dosage: 0.3% ointment Sig: Apply to both eyes QID x 5 days

Dispense: 1 Refills: 0 Allow Generic: Yes

John Smith, M.D.

Sample Prescription
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John Smith, M.D.

DEA#:

Name: Gabriella Kraemer
Address:
WDM, IA 50266

Date: 07/30/2003

Tobramycin ophthalmic
0.3% ointment
Apply to both eyes QID x 5 days

X _____
X _____

Substitution Permitted

Dispense as written

Refills: 0

Disp: 1

Allow Generic: Yes

Sample Patient Instruction
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Patient Instructions for Gabriella Kraemer on 07/30/2003

CONJUNCTIVITIS (Pink Eye)
Patient Information

What is Conjunctivitis?

Conjunctivitis, better known as Pink Eye, is an infection of the inside of your eyelid. It is usually caused by allergies, bacteria, viruses, or chemicals.

What are the signs and symptoms?

1. Red, irritated eye.
2. Some burning and/or scratchy feeling.
3. There may be a purulent (pus) or a mucous type discharge.

How is it treated?

It depends on what caused the Pink Eye. It may or may not need medication for treatment. If medication is given, follow the directions on the label.

What else do I need to know?

To prevent the spread of the infection:

1. Wash hands thoroughly
Before you use the medicine in your eyes.
After using the medicine in your eyes.
Every time you touch your eyes or face.
2. Wash any clothing touched by infected eyes.
Clothes
Towels
Pillowcases
3. Do not share make-up. If the infection is caused by bacteria or a virus you must throw away your used make-up and buy new make-up.
4. Do not touch the infected eye because the infection will spread to the good eye.
IMPORTANT!!!
5. Pink Eye Spreads Very Easily!

John Smith, M.D.

Sample Billing Statement
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Billing Statement - Wednesday, July 30, 2003

Provider: John Smith, M.D.
Patient: Gabriella Kraemer, Chart 16881
1025 Ashworth Road, Suite 222
West Des Moines, IA 50265

Diagnoses

1. V20.2 Routine Infant Or Child Health Check
2. 372.00 Acute Conjunctivitis, Unspecified

Treatments

1. 83655 Lead
Related Diagnoses: V20.2
Modifiers:
Units:
2. 90396 Varicella-Zoster Immune Globulin, Human, For Intramuscular Use
Related Diagnoses: V20.2
Modifiers:
Units:
3. 83020 Hemoglobin Fractionation And Quantitation; Electrophoresis (eg, A2, S, C, And/Or F)
Related Diagnoses: V20.2
Modifiers:
Units:
4. 99212 Office or other outpatient visit - est. patient - 10 min.
Related Diagnoses: V20.2
Modifiers:
Units:

Referring Physician: Marcus Welby, M.D.
Date Last Seen:

Sample History and Physical Note
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Subjective: Chief Complaint (1/1): This 3 year-old female presents today for evaluation of ear pain and fullness in the ear bilateral.

Associated signs and symptoms for otitis media: Associated signs and symptoms include: speech and language delay, irritability, cough, runny nose and loss of hearing.

Context: Prior history of this condition exists, 14th bout with otitis media.

Duration: Condition has existed for 2 years.

Modifying factors: Parent indicates prior treatments have been ineffective.

Quality: Quality of the pain is described by the patient as throbbing.

Severity: Severity of condition is worsening.

Eating is poor.

Child is up frequently in the night.

Date of last exam was 7/22/2003.

PFSH: Social History: She is in a large daycare.

Medication History: Patient is currently using Augmentin. Patient is no longer using Zithromax or amoxicillin.

Review of Systems: Integumentary: (+) eczema, **Gastrointestinal:** (+) appetite poor or changed, **Ears, Nose, Mouth, Throat:** (+) cough, productive, (+) difficulty with hearing, (+) runny nose, **Constitutional Symptoms:** (+) appetite decrease, (+) sleep problems, **Allergic / Immunologic:** (-) unremarkable, **Cardiovascular:** (-) unremarkable, **Endocrine:** (-) unremarkable, **Eyes:** (-) unremarkable, **Genitourinary:** (-) unremarkable, **Hematologic / Lymphatic:** (-) unremarkable, **Musculoskeletal:** (-) unremarkable, **Psychiatric:** (-) unremarkable.

Objective: The physical exam is updated as follows. Temp: 99.8 Weight: 38 lbs.

Patient is a 3 year old female who appears well developed and well nourished.

Inspection of head and face shows head that is normocephalic, atraumatic, without any gross or neck masses.

Conjunctiva and lids reveal no signs or symptoms of infection.

Inspection of bilateral ears reveals no masses or swelling.

Otoscopic examination reveals bulging tympanic membrane, opaque, and with poor mobility bilaterally. Tympanic membrane mobility was tested by a pneumatic otoscope.

Inspection of nasal mucosa, septum and turbinates reveals erythema.

Examination of oropharynx reveals no abnormalities.

Neck exam reveals no masses.

Neck lymph nodes are normal.

Auscultation of lungs reveal clear lung fields and no rales noted.

Heart auscultation reveals rate is regular, rhythm is regular and no murmurs, gallop, rales or clicks.

Abdomen soft, nontender, bowel sounds present x 4 without palpable masses.

Test Results: No tests to report at this time

Assessment: Chronic purulent otitis media.

Plan: The plan is to continue with course of Augmentin treatment from last visit. Patient was referred to otolaryngology.

_____ John Smith, M.D.

Sample Referral Letter
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08/01/2003

Andrew Otolaryngologist
1025 Ashworth Road, Suite 222
West Des Moines, IA 50265

Dear Dr. Otolaryngologist:

Elizabeth Otten was seen in my office. I have requested that Elizabeth be seen by you for further evaluation of chronic otitis media and possible insertion of ear tubes. The following is a summary of my findings:

Subjective: Chief Complaint (1/1): This 3 year-old female presents today for evaluation of ear pain and fullness in the ear bilateral.

Associated signs and symptoms for otitis media: Associated signs and symptoms include: speech and language delay, irritability, cough, runny nose and loss of hearing.

Context: Prior history of this condition exists, 14th bout with otitis media.

Duration: Condition has existed for 2 years.

Modifying factors: Parent indicates prior treatments have been ineffective.

Quality: Quality of the pain is described by the patient as throbbing.

Severity: Severity of condition is worsening.

Eating is poor.

Child is up frequently in the night.

Date of last exam was 7/22/2003.

PFSH: Social History: She is in a large daycare.

Medication History: Patient is currently using Augmentin. Patient is no longer using Zithromax or amoxicillin.

Review of Systems: Integumentary: (+) eczema, **Gastrointestinal:** (+) appetite poor or changed, **Ears, Nose, Mouth, Throat:** (+) cough, productive, (+) difficulty with hearing, (+) runny nose, **Constitutional Symptoms:** (+) appetite decrease, (+) sleep problems, **Allergic /**

Immunologic: (-) unremarkable, **Cardiovascular:** (-) unremarkable, **Endocrine:** (-)

unremarkable, **Eyes:** (-) unremarkable, **Genitourinary:** (-) unremarkable, **Hematologic /**

Lymphatic: (-) unremarkable, **Musculoskeletal:** (-) unremarkable, **Psychiatric:** (-) unremarkable.

Objective: The physical exam is updated as follows. Temp: 99.8 Weight: 38 lbs.

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Inspection of nasal mucosa, septum and turbinates reveals erythema.

Examination of oropharynx reveals no abnormalities.

Neck exam reveals no masses.

Neck lymph nodes are normal.

Auscultation of lungs reveal clear lung fields and no rales noted.

Heart auscultation reveals rate is regular, rhythm is regular and no murmurs, gallop, rubs or clicks.

Abdomen soft, nontender, bowel sounds present x 4 without palpable masses.

Test Results: No tests to report at this time

Assessment:

Chronic purulent otitis media.

Plan: The plan is to continue with course of Augmentin treatment from last visit. Patient was referred to otolaryngology.

If I may be of any further assistance in your evaluation of this patient, please contact me. Let me know your findings and recommendations. Thank you for assisting in the care of this patient.

Sincerely,

John Smith, M.D.

Sample Billing Statement
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Billing Statement - Friday, August 01, 2003

Provider: John Smith, M.D.
Patient: Elizabeth M Otten, Chart 14988
1025 Ashworth Road, Suite 222
West Des Moines, IA 50266

Diagnoses

1. 382.3 Unspecified Chronic Suppurative Otitis Media

Treatments

1. 99214 Office or other outpatient visit - est. patient - 25 min.
Related Diagnoses:
Modifiers:
Units:

Referring Physician:
Date Last Seen: 7/22/03