

Page 1 of 3		Neuro	Body																																												
<h1>ARA</h1>		History and Physical Examination		<b>Patient Name:</b> _____ <b>Date of Birth:</b> _____ <b>How would you like to be contacted in the future for follow-ups?</b> _____ <b>home phone #:</b> _____ _____ <b>work phone #:</b> _____ _____ <b>Alternate phone #:</b> _____ _____ <b>Other:</b> _____																																											
Austin Radiological Association		Consulting MD		<b>How did you hear about us?</b> _____ <b>Referred by Dr.</b> _____ _____ <b>Radio</b> _____ <b>TV</b> _____ <b>Print ad in:</b> _____ _____ <b>Friend/family member</b> _____ <b>Internet Web Site:</b> _____																																											
Interventional Radiology 901 W. 38 <sup>th</sup> St. Suite 100 Austin TX 78705 (512) 926-3876 / (512) 467-9729		Dutton Karnaze Jhaveri Manning	Hsu Gunlock Kish Fletcher																																												
HPI (History of Present Illness) elements: Include 4 or more HPI elements or the status of 3 or more chronic or inactive conditions		Location Quality	Severity Duration	Timing Context	Modifying Factors Associated signs and symptoms																																										
3 chronic or inactive conditions																																															
Date:	Time:	<b>Who is your primary care physician?</b>		<b>What other doctors have you been seeing for this condition?</b>																																											
History obtained from:	Patient _____ Family Member _____ Acquaintance _____																																														
Chief Complaint (reason for admit):	<b>Please describe the problem that you are here to discuss. Please rate pain on a scale of 1-10, with 10 being the worst pain you have ever experienced.</b>																																														
HPI:	<b>How long have you had this problem? How did it start?</b>																																														
Allergies:	<b>What medications are you allergic to?</b>																																														
Medications:	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">Name</th> <th style="width:15%;">Dose</th> <th style="width:15%;">Indication</th> <th style="width:33%;">Name</th> <th style="width:15%;">Dose</th> <th style="width:15%;">Indication</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>					Name	Dose	Indication	Name	Dose	Indication																																				
Name	Dose	Indication	Name	Dose	Indication																																										
Procedure History Surg/Med:	<b>Please list any health problems that you have had in the past and present.</b>		<b>Please list any surgeries that you have had in the past.</b>																																												
Social History:																																															
Risk Factors:	Alcohol _____ Tobacco _____ Tuberculosis _____ BBP _____																																														
Family History:																																															
Studies/Meds/Labs Ordered/Reviewed																																															

(continued next page)

Technician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

ROS:

Please mark any symptoms that you have with an X.

- |   |   |  |
|---|---|--|
| <p><b>General:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> fevers</li> <li><input type="checkbox"/> appetite loss</li> <li><input type="checkbox"/> fatigue</li> <li><input type="checkbox"/> "feeling sick"</li> </ul> <p><b>Eyes:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> double vision</li> <li><input type="checkbox"/> blurring</li> <li><input type="checkbox"/> discharge</li> <li><input type="checkbox"/> eye pain</li> <li><input type="checkbox"/> eye irritation</li> </ul> <p><b>E/N/T:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> earache</li> <li><input type="checkbox"/> hoarseness</li> <li><input type="checkbox"/> nosebleed</li> <li><input type="checkbox"/> ear discharge</li> <li><input type="checkbox"/> sore throat</li> </ul> <p><b>Cardio:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> near fainting</li> <li><input type="checkbox"/> fainting</li> <li><input type="checkbox"/> palpitations</li> <li><input type="checkbox"/> leg cramps</li> <li><input type="checkbox"/> racing heart</li> <li><input type="checkbox"/> difficulty breathing while lying down</li> </ul> <p><b>Respiratory:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> cough</li> <li><input type="checkbox"/> wheezing</li> <li><input type="checkbox"/> excessive sputum</li> <li><input type="checkbox"/> excessive snoring</li> </ul> <p><b>GI:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> gas</li> <li><input type="checkbox"/> nausea</li> <li><input type="checkbox"/> indigestion</li> <li><input type="checkbox"/> vomiting</li> <li><input type="checkbox"/> diarrhea</li> <li><input type="checkbox"/> hemorrhoids</li> <li><input type="checkbox"/> constipation</li> </ul> <p><b>Genitourinary:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> urinary frequency</li> <li><input type="checkbox"/> kidney pain</li> <li><input type="checkbox"/> pelvic pain</li> <li><input type="checkbox"/> blood in urine</li> <li><input type="checkbox"/> genital sores</li> <li><input type="checkbox"/> missed periods</li> <li><input type="checkbox"/> night time urination</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> chills</li> <li><input type="checkbox"/> weight loss</li> <li><input type="checkbox"/> sweats</li> </ul> <p><b>Musculoskeletal:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> gout</li> <li><input type="checkbox"/> stiffness</li> <li><input type="checkbox"/> back pain</li> <li><input type="checkbox"/> arthritis</li> </ul> <p><b>Skin:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> rash</li> <li><input type="checkbox"/> itching</li> <li><input type="checkbox"/> dryness</li> <li><input type="checkbox"/> skin cancer</li> <li><input type="checkbox"/> night sweats</li> </ul> <p><b>Neurologic:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> headaches</li> <li><input type="checkbox"/> fainting</li> <li><input type="checkbox"/> seizures</li> <li><input type="checkbox"/> weakness</li> <li><input type="checkbox"/> numbness</li> <li><input type="checkbox"/> difficulty with concentration</li> <li><input type="checkbox"/> disturbances in coordination</li> <li><input type="checkbox"/> sensation of room spinning</li> </ul> <p><b>Psychiatric:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> anxiety</li> <li><input type="checkbox"/> depression</li> <li><input type="checkbox"/> mental problems</li> <li><input type="checkbox"/> frightening visions or sounds</li> </ul> <p><b>Endocrine:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> heat intolerance</li> <li><input type="checkbox"/> cold intolerance</li> <li><input type="checkbox"/> excessive hunger</li> </ul> <p><b>Heme/Lymphatic:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> bleeding</li> <li><input type="checkbox"/> fevers</li> <li><input type="checkbox"/> abnormal bruising</li> </ul> <p><b>Allergic:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> seasonal allergies</li> <li><input type="checkbox"/> persistent infection</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> muscle cramps</li> <li><input type="checkbox"/> joint swelling/pain</li> <li><input type="checkbox"/> muscle weakness</li> <li><input type="checkbox"/> loss of strength</li> </ul> <ul style="list-style-type: none"> <li><input type="checkbox"/> suspicious lesions</li> <li><input type="checkbox"/> poor wound healing</li> <li><input type="checkbox"/> excessive perspiration</li> <li><input type="checkbox"/> changes in color of skin</li> <li><input type="checkbox"/> changes in nail beds</li> </ul> <ul style="list-style-type: none"> <li><input type="checkbox"/> falling down</li> <li><input type="checkbox"/> poor balance</li> <li><input type="checkbox"/> memory loss</li> <li><input type="checkbox"/> brief paralysis</li> <li><input type="checkbox"/> visual disturbances</li> </ul> <ul style="list-style-type: none"> <li><input type="checkbox"/> thoughts of suicide</li> <li><input type="checkbox"/> thoughts of violence</li> <li><input type="checkbox"/> sense of great danger</li> </ul> <ul style="list-style-type: none"> <li><input type="checkbox"/> weight change</li> <li><input type="checkbox"/> excessive thirst</li> <li><input type="checkbox"/> excessive urination</li> </ul> <ul style="list-style-type: none"> <li><input type="checkbox"/> enlarged lymph node</li> <li><input type="checkbox"/> skin discoloration</li> </ul> <ul style="list-style-type: none"> <li><input type="checkbox"/> hives or rash</li> <li><input type="checkbox"/> HIV exposure</li> </ul> |
|---|---|--|

PE:

T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ SaO2: \_\_\_\_\_

EYES:

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ BP: \_\_\_\_\_ Left \_\_\_\_\_ Right

HENT:

SKIN:

HEART:

LUNGS:

CHEST/BREASTS



ABDOMEN:	
PELVIC/RECTAL	
EXTREMETIES	
NEUROLOGIC:	
HEM/LYMPH:	
PSYCHOLOGIC:	

DIAGNOSIS	
IMPRESSION/ ASSESSMENT	
TREATMENT PLAN	

\_\_\_\_\_minutes in consultation with the family. Issues discussed:

**DO NOT ABBREVIATE**

DIAGNOSIS #1: \_\_\_\_\_

DIAGNOSIS #2: \_\_\_\_\_

DIAGNOSIS #3: \_\_\_\_\_

DIAGNOSIS #4: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Final Result for Complexity of Medical Decision Making 2 out of 3 Required		
A	B	C
Number of Diagnoses or Management Options	Amount and Complexity of Data to be reviewed	Overall Risk
≤ 1 Minimal	≤1 Minimal or low	Minimal
2 Limited	2 Limited	Low
3 Multiple	3 Moderate	Moderate
≥4 Extensive	≥4 Extensive	High

IDX ACC# \_\_\_\_\_

DICTATION JOB # \_\_\_\_\_

Technician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_