

# E. C. Tyree Dental and Health Clinic

Date: _____	weight: _____	BP: _____	RR: _____
Name: _____	height: _____	HR: _____	SaO <sub>2</sub> _____
DOB: _____	BMI: _____ Kg/m <sup>2</sup>	Temp: _____ °F	Other: _____
Age: _____			

CC: \_\_\_\_\_ Historian: MT|Self, MTH, FTH, GM, GF, Other \_\_\_\_\_

<b>HPI:</b> loc, context, qual, severity, duration, timing, mod factors, assoc. sx Circle Positives X Negatives Cough Nasal Congestion Runny Nose Watery/Itchy (nose/eyes) Ear Drainage Earache (L or R) Eye Drainage Pink/Red eye (L or R) Fever Fussy/Irritable SOB/Wheeze Headache Sore Throat Swollen Glands Stomach ache <input type="checkbox"/> intake (food/drink) Rash Nausea/Vomit Diarrhea Constipation Urination (decrease vol /increased frequency/pain/burning/wet pant/urgency)	<b>ROS:</b> (0,1,2,10) Circle Positive X Negatives <input type="checkbox"/> All other symptoms negative except per HPI GEN wt loss, fatigue, fever, poor appetite EYES red, watery, mattering, vision change ENT otalgia, rhinitis, congestion, pharyngitis, halitosis RESP cough, wheeze, tachypnea, pain CV palpitations, syncope, pain GI v, n, d, c, bloody stool, pain GU dysuria, nocturia burning, itching M/Sk myalgia, arthralgia, injury SKIN rash, abrasion, bruise NEURO fussy, irritable, syncope, numbness PSYCH sleep change, behavior change ENDO polydipsia, polyuria, fatigue, menstrual HEME/LYMPH epistaxis, bruise, petechiae, LAD ALL/Imm rhinitis, itchy eyes, sneezing, rash
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Meds: <input type="checkbox"/> None or _____ Allergies: <input type="checkbox"/> NKDA or _____ Immun: <input type="checkbox"/> UTD <input type="checkbox"/> Behind <input type="checkbox"/> Request parent to provide rec.	P/F/S Hx: (0,0,1,3) <input type="checkbox"/> form reviewed <input type="checkbox"/> Depression <input type="checkbox"/> daycare/school <input type="checkbox"/> smoking exposure <input type="checkbox"/> Dentist _____ <input type="checkbox"/> PCP _____
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**PHYSICAL EXAM**

	NL	Abn	Circle Positives
Const	<input type="checkbox"/>	<input type="checkbox"/>	WNWD, Appears stated age, Alert, Oriented, Cooperative, no distress
Gen	<input type="checkbox"/>	<input type="checkbox"/>	alert/active, ill, fussy, not cooperative
Head	<input type="checkbox"/>	<input type="checkbox"/>	NC/AT, AFSF, AF: protruded/sunken
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Conjunctive, clear, PERRLA, EOMI, Rethal vessels, disc margin sharp, red, mattering, edema, allergic, shiners
Ears L	<input type="checkbox"/>	<input type="checkbox"/>	red, dull, bulge ↓ mobility, fluid level, tube, no sinus tenderness, nasal mucosa
R	<input type="checkbox"/>	<input type="checkbox"/>	red, dull, bulge ↓ mobility, fluid level, tube, no sinus tenderness, nasal mucosa
Canals	<input type="checkbox"/>	<input type="checkbox"/>	↑ cerumen (L/R), red, pain, purulent d/c
Nose	<input type="checkbox"/>	<input type="checkbox"/>	drainage (clear/pur), boggy turbs,
Throat	<input type="checkbox"/>	<input type="checkbox"/>	injected, ulcers, enlarged tonsils, drainage
Neck	<input type="checkbox"/>	<input type="checkbox"/>	FROM, LAD, meningismus, retractions
Chest	<input type="checkbox"/>	<input type="checkbox"/>	wheeze i a/e, coarse, ronchi, retractions
CV	<input type="checkbox"/>	<input type="checkbox"/>	RRR w/0 or w ____/VJ, murmur, no rub ____, no thrill ____, no periph edema, no bruits, pulses full and equal
Abd	<input type="checkbox"/>	<input type="checkbox"/>	S/NT/ND/NABS, HSM, mass
GU	<input type="checkbox"/>	<input type="checkbox"/>	testes l, labial adhesions, discharge
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Rash, Erythema, Scaly, Blister, Papula, Macule, Pus, Border Discrete, Bruise, Petechiae, Abrasions
M/Sk	<input type="checkbox"/>	<input type="checkbox"/>	FROM
Neuro	<input type="checkbox"/>	<input type="checkbox"/>	Oriented, Good Tone, Strength, DTR ____/4 UE / LE, CN Grossly, Gait
Oral	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils ____/4 R, ____/4L, No Inect ____/Exedates, Orapharynx WNL, No Caries
Resp	<input type="checkbox"/>	<input type="checkbox"/>	LSCTA & P, No Distress, Cough, Rales, Rhonchi, Wheeze
Breasts	<input type="checkbox"/>	<input type="checkbox"/>	Symmetric / No Leasions, No Masses, Tenderness, Nipple Discharge
Rectal	<input type="checkbox"/>	<input type="checkbox"/>	Norm Sphin tone, Hemorrhoid, Mass, Hemocult Nog

LMP _____ LPS _____ G _____ P _____ A _____ L _____	Menarche: _____ Menses _____ days for _____ days	L / M / H Flow
PMH charted/updated PSH charted/updated	FH: charted/updated SH charted/updated	Ma / Si / Di / Wi
HTN DM / MI / Seizure Hyst / Salpin BL, R, L	HTN _____ DM _____ CAD _____	Student/Employed/Disabled/ _____
Asthma / COPD / Cancer Cholecyst / T&A / Append	Cancer _____	Tob: No / _____ PPD Etch No / _____ Drugs _____
Other: _____	Other: _____	Other: _____

**Assessment and Plan**

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F/U if sxs worsen or presistent or in _____ Pt ed. h/o	99202 / 99212	
re: _____	99203 / 99213	Procedure _____
	99204 / 99214	_____
	99205 / 99215	Provider Signature _____ Date _____