

Sample Physical Exam Documentation

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Under pressure to be efficient, most providers abbreviate physical exam documentation to just the necessities. There is a fine balance between spending too much time on charting and including too little in your documentation. The amount you are paid for each patient encounter is based on your documentation, so cutting corners can directly affect your wallet. With time, you'll learn to strike ...

Cheat Sheet: Normal Physical Exam Template | ThriveAP

A Physical Examination is a process wherein a medical practitioner goes through the body of a patient and checks for any sign of disease. Physical Exams usually begin with the documentation of the patient's medical history, which serves as an aid for the practitioner to determine the correct diagnosis and to devise a plan of treatment.

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PE Sample 1. Physical Exam Format 2: Subheadings in ALL CAPS and transcribed in paragraph format. PHYSICAL EXAM: GENERAL APPEARANCE: The patient is a well-developed, well-nourished female/male in no acute distress. VITAL SIGNS: Blood pressure [x] mmHg, pulse rate [x] beats per minute, respirations [x] breaths per minute, temperature [x] degrees Celsius/Fahrenheit, and O2 saturation [x] on ...

Normal Physical Exam Template Samples - MT Sample Reports

Infant PE Sample PHYSICAL EXAMINATION: On physical exam, the patient appears his stated age and has mesomorphic body habitus, appears in no acute distress. Head, neck, and upper extremities are grossly normal and symmetric. As we travel down his lower back, there is some bilateral pain.

Physical Examination Medical Transcription Samples

Physical Exam 1. Vital Signs: temperature 100.2 Pulse 96 regular with occasional extra beat, respiration 24, blood pressure 180/100 lying down 2. Generally a well developed, slightly obese, elderly black woman sitting up in bed, breathing with slight difficulty.

Example of a Complete History and Physical Write-up

HEENT Section Physical Examination Transcription Examples. HEENT: Eyes: No scleral icterus or xanthelasma. Mouth: No oral pallor or cyanosis. HEENT: Head and Face: No facial plethora. No signs of trauma. Eyes: Pupils equal and reactive to light bilaterally. Oral cavity pink and moist. There is no oropharyngeal erythema, no exudate. Uvula is midline. There is no swelling, no retropharyngeal ...

HEENT Section Physical Examination Transcription Examples

Normal Physical Examination Template Format For Medical Transcriptionists. PHYSICAL EXAM TEMPLATE FORMAT # 1: PHYSICAL EXAMINATION: GENERAL APPEARANCE: The patient is alert, oriented and has a bandage over his left eye. He is in no acute distress. VITAL SIGNS: T-max was 100, currently 97.5, blood pressure 110/60, respirations 22, and heart rate 88.

Normal Physical Examination Template Format For Medical ...

History and Physical Examination (H&P) Examples . The links below are to actual H&Ps written by UNC students during their inpatient clerkship rotations. The students have granted permission to have these H&Ps posted on the website as examples. H&P 1 "77 yo woman - swelling of tongue and difficulty breathing and swallowing" H&P 2 "47 yo woman - abdominal pain" H&P 3 "56 yo man ...

History and Physical Examination (H&P) Examples | Medicine ...

Nursing assessment is an important step of the whole nursing process. Assessment can be called the "base or foundation" of the nursing process. With a weak or incorrect assessment, nurses can create an incorrect nursing diagnosis and plans therefore creating wrong interventions and evaluation. To prevent those kind of scenarios, we have created a cheat sheet that you can print and use to ...

Complete Head-to-Toe Physical Assessment Cheat Sheet ...

Ear, nose and throat examination documentation. Example documentation of a normal ENT examination. Example documentation of an abnormal ENT examination . Clinical Skills Teaching and Learning Centre. 70 Pembroke Place L69 3GF Liverpool United Kingdom. 0151 794 8242. clinicalskills@liverpool.ac.uk. 8.15 - 16.15 ...

Ear, nose and throat examination documentation - Clinical ...

There are a few terms you may encounter in the physical exam of the neck and back that can be helpful to include in your documentation. Familiarize yourself with these terms as you perfect your exam and documentation technique: Antalgic Gait - Occurs when the patient avoids bearing weight on one leg due to pain. The patient bears weight on the affected extremity for the shortest possible ...

Documenting a Back and Neck Exam Made Simple | ThriveAP

Normal breast examination documentation. Abnormal breast examination documentation. Clinical Skills Teaching and Learning Centre. 70 Pembroke Place L69 3GF Liverpool United Kingdom. 0151 794 8242. clinicalskills@liverpool.ac.uk. 8.15 - 16.15 ...

Breast Examination documentation examples - Clinical ...

• The Telemedicine physical exam relies on inspection and observation rather than palpation. However, several telemedicine programs advocate the use of patient self-palpation o. Self-palpation of the lower extremities under my guidance yielded 1+ pitting edema • As with an in person visit, documentation o f important negative findings in conjunction with clear discharge instructions ...

Telehealth Physical Exam

Comprehensive Adult History and Physical (Sample Summative H&P by M2 Student) Chief Complaint: "I got lightheadedness and felt too weak to walk" Source and Setting: Patient reported in an in-patient setting on Day 2 of his hospitalization. History of Present Illness: Patient is a 48 year-old well-nourished Hispanic male with a 2-month history of Rheumatoid Arthritis and strong family ...

Comprehensive Adult History and Physical This sample ...

DATA BASE SAMPLE: PHYSICAL EXAMINATION WITH ALL NORMAL FINDINGS GENERAL APPEARANCE: (include general mental status) 45 y/o female who is awake and alert and who appears healthy and looks her stated age VITALS Temperature: 37.5° C oral (list the site where the temperature was taken, i.e., oral, rectal, tympanic membrane, axillary) Blood Pressure: R Arm/Palpation (Systolic)- 120 R Arm ...

DATA BASE SAMPLE: PHYSICAL EXAMINATION WITH ALL NORMAL ...

Sample Basic Normal Exam Documentation Documentation of a basic, normal neuro exam should look something along the lines of the following: The patient is alert and oriented to person, place, and time with normal speech. No motor deficits are noted, with muscle strength 5/5 bilaterally.

Documenting a Neuro Exam, Decoded | ThriveAP

The 1997 guidelines define mandatory physical exam elements and called them Bullets. A comprehensive exam requires all bulleted items to be examined, and at least 2 per system to be documented. The full list of bullets is in the appendix at the end of this post.

ED Charting and Coding: Physical Exam (PE)

Sample Write-Ups Sample Neurological H&P CC: The patient is a 50-year-old right-handed woman with a history of chronic headaches who complains of acute onset of double vision and right eyelid droopiness three days ago. History of present illness: Mrs. Smith states that on Sunday evening (7/14/03) about 20 minutes after sitting down to work at her computer, she developed blurred vision, which ...

Sample Write-Ups - Neurology

Physical Examination Vitals T36.9 P104 R24 BP139/91 O2 sats : 95%RA General NAD, resting on stretcher and very alert during interview Eyes sclera and conjunctiva clear, EOMI, PERRLA, no ptosis.