

ADULT PROGRESS NOTE

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

Date: _____

New Return Periodic

Chart Not Available Interval ED Visit Interval Admission Allergies: Yes (See Adult Summary Form)
 Missed App't(s) Needs Prescriptions No

CC: _____

 _____ Initial: _____

HPI: (Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Assoc. Signs/Symptoms)

Medications: None See Updated Med List

Review of Systems:

- | | | | | |
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| <p>+ - Constitutional
 <input type="checkbox"/> <input type="checkbox"/> Change Wt
 <input type="checkbox"/> <input type="checkbox"/> Fatigue
 <input type="checkbox"/> <input type="checkbox"/> Temperature/Chills
 <input type="checkbox"/> <input type="checkbox"/> Weakness</p> <p>Skin
 <input type="checkbox"/> <input type="checkbox"/> Change Color
 <input type="checkbox"/> <input type="checkbox"/> Change Hair/Nails
 <input type="checkbox"/> <input type="checkbox"/> New Lesions
 <input type="checkbox"/> <input type="checkbox"/> Pruritis
 <input type="checkbox"/> <input type="checkbox"/> Rash
 <input type="checkbox"/> <input type="checkbox"/> Xerosis</p> <p>Eyes
 <input type="checkbox"/> <input type="checkbox"/> Cataracts
 <input type="checkbox"/> <input type="checkbox"/> Change Vision
 <input type="checkbox"/> <input type="checkbox"/> Glaucoma
 <input type="checkbox"/> <input type="checkbox"/> Redness</p> <p>ENT
 <input type="checkbox"/> <input type="checkbox"/> Bleeding Gums
 <input type="checkbox"/> <input type="checkbox"/> Change Hearing
 <input type="checkbox"/> <input type="checkbox"/> Change Voice
 <input type="checkbox"/> <input type="checkbox"/> Deafness
 <input type="checkbox"/> <input type="checkbox"/> Epistaxis
 <input type="checkbox"/> <input type="checkbox"/> Hoarseness
 <input type="checkbox"/> <input type="checkbox"/> Sinusitis</p> | <p>+ - <input type="checkbox"/> <input type="checkbox"/> Tinnitus
 <input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p>Respiratory
 <input type="checkbox"/> <input type="checkbox"/> Asthma
 <input type="checkbox"/> <input type="checkbox"/> Bronchitis
 <input type="checkbox"/> <input type="checkbox"/> Cough
 <input type="checkbox"/> <input type="checkbox"/> DOE
 <input type="checkbox"/> <input type="checkbox"/> Hemoptysis
 <input type="checkbox"/> <input type="checkbox"/> Pneumonia
 <input type="checkbox"/> <input type="checkbox"/> SOB</p> <p>Cardiovascular
 <input type="checkbox"/> <input type="checkbox"/> Angina
 <input type="checkbox"/> <input type="checkbox"/> CAD
 <input type="checkbox"/> <input type="checkbox"/> Chest Pain
 <input type="checkbox"/> <input type="checkbox"/> Claudication
 <input type="checkbox"/> <input type="checkbox"/> DOE
 <input type="checkbox"/> <input type="checkbox"/> Edema
 <input type="checkbox"/> <input type="checkbox"/> HTN
 <input type="checkbox"/> <input type="checkbox"/> Orthopnea
 <input type="checkbox"/> <input type="checkbox"/> Palpitations
 <input type="checkbox"/> <input type="checkbox"/> PND
 <input type="checkbox"/> <input type="checkbox"/> Change Bowel Habits</p> <p>Gastrointestinal
 <input type="checkbox"/> <input type="checkbox"/> BRBPR
 <input type="checkbox"/> <input type="checkbox"/> Change Bowel Habits</p> | <p>+ - <input type="checkbox"/> <input type="checkbox"/> Constipation
 <input type="checkbox"/> <input type="checkbox"/> Diarrhea
 <input type="checkbox"/> <input type="checkbox"/> Dysphagia
 <input type="checkbox"/> <input type="checkbox"/> Fecal Incontinence
 <input type="checkbox"/> <input type="checkbox"/> GERD
 <input type="checkbox"/> <input type="checkbox"/> Hematochezia
 <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids
 <input type="checkbox"/> <input type="checkbox"/> Melena
 <input type="checkbox"/> <input type="checkbox"/> N/V
 <input type="checkbox"/> <input type="checkbox"/> PUD</p> <p>Genitourinary
 <input type="checkbox"/> <input type="checkbox"/> Change Stream
 <input type="checkbox"/> <input type="checkbox"/> Hematuria
 <input type="checkbox"/> <input type="checkbox"/> Hemia
 <input type="checkbox"/> <input type="checkbox"/> Hesitancy
 <input type="checkbox"/> <input type="checkbox"/> Incontinence
 <input type="checkbox"/> <input type="checkbox"/> Incontinence
 <input type="checkbox"/> <input type="checkbox"/> Nocturia
 <input type="checkbox"/> <input type="checkbox"/> Polyuria
 <input type="checkbox"/> <input type="checkbox"/> Scrotal Masses/Pain
 <input type="checkbox"/> <input type="checkbox"/> STD's
 <input type="checkbox"/> <input type="checkbox"/> Urgency</p> | <p>+ - <input type="checkbox"/> <input type="checkbox"/> Arthritis
 <input type="checkbox"/> <input type="checkbox"/> Cervical Pain
 <input type="checkbox"/> <input type="checkbox"/> Decreased Motion
 <input type="checkbox"/> <input type="checkbox"/> Gout
 <input type="checkbox"/> <input type="checkbox"/> Injuries
 <input type="checkbox"/> <input type="checkbox"/> Joint Pain
 <input type="checkbox"/> <input type="checkbox"/> Joint Stiffness
 <input type="checkbox"/> <input type="checkbox"/> Locking Joints
 <input type="checkbox"/> <input type="checkbox"/> Low Back Pain
 <input type="checkbox"/> <input type="checkbox"/> Swelling</p> <p>Psychiatric
 <input type="checkbox"/> <input type="checkbox"/> Depression
 <input type="checkbox"/> <input type="checkbox"/> Homicidal Ideation
 <input type="checkbox"/> <input type="checkbox"/> Substance Abuse
 <input type="checkbox"/> <input type="checkbox"/> Suicidal Ideation
 <input type="checkbox"/> <input type="checkbox"/> Time/Place Orientation
 <input type="checkbox"/> <input type="checkbox"/> Recent/Remote Memory
 <input type="checkbox"/> <input type="checkbox"/> Anxiously/Agitation</p> <p>Female Reprod.
 <input type="checkbox"/> <input type="checkbox"/> Abnormal Menses
 <input type="checkbox"/> <input type="checkbox"/> Dryness
 <input type="checkbox"/> <input type="checkbox"/> Dyspareunia
 <input type="checkbox"/> <input type="checkbox"/> Sexual Abuse
 <input type="checkbox"/> <input type="checkbox"/> Vaginal Discharge</p> | <p>+ - <input type="checkbox"/> <input type="checkbox"/> Breast Pain
 <input type="checkbox"/> <input type="checkbox"/> Breast Lumps
 <input type="checkbox"/> <input type="checkbox"/> Breast Discharge</p> <p>Endocrine
 <input type="checkbox"/> <input type="checkbox"/> Heat/Cold Intol.
 <input type="checkbox"/> <input type="checkbox"/> Neck Enlargement
 <input type="checkbox"/> <input type="checkbox"/> Polydipsia
 <input type="checkbox"/> <input type="checkbox"/> Xerosis</p> <p>Neurologic
 <input type="checkbox"/> <input type="checkbox"/> Change Concentration
 <input type="checkbox"/> <input type="checkbox"/> Change Memory
 <input type="checkbox"/> <input type="checkbox"/> Dizziness
 <input type="checkbox"/> <input type="checkbox"/> Headache
 <input type="checkbox"/> <input type="checkbox"/> Imbalance
 <input type="checkbox"/> <input type="checkbox"/> Numbness
 <input type="checkbox"/> <input type="checkbox"/> Seizures
 <input type="checkbox"/> <input type="checkbox"/> Tinnitus
 <input type="checkbox"/> <input type="checkbox"/> Weakness</p> <p>Hematologic
 <input type="checkbox"/> <input type="checkbox"/> Anemia
 <input type="checkbox"/> <input type="checkbox"/> Easy Bruisability
 <input type="checkbox"/> <input type="checkbox"/> Enlarged LN's
 <input type="checkbox"/> <input type="checkbox"/> Hx Transfusions</p> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------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Comments: _____

PMH Reviewed – No Changes; See Adult Summary Form PMH Reviewed & Updated; See Adult Summary Form

Mental Health Progress Note Terms

M Carnoy



Mental Health Progress Note Terms:

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