

Date: _____

PROGRESS NOTE

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 Fort Worth, TX 76104
 817-334-0003

Patient Name: _____ DOB: _____

PHYSICAL EXAM: ☒ NORMAL - ☒ ABNORMAL

Vitals: Ht: _____ Wt: _____ BMI: _____ Temp: _____ 02: _____ RR: _____ BP: _____ / _____ Pulse: _____		CHEST Shape _____ Respirations _____ Symmetry _____ Other _____ BREAST Masses _____ Nipples _____ Discharge _____ Axilla _____ HEART Apical Impulse _____ Murmurs _____ Rhythm _____ Gallop _____ Rub _____ Other _____ LUNGS Percussion _____ Wheeze _____ Breath Sounds _____ Rub _____ Adventitious Sounds _____ Other _____ BLOOD VESSELS Pulses _____ Quality _____ Bruit _____		GENITOURINARY - FEMALE External _____ Adnexa _____ Vagina _____ Discharge _____ Urethra _____ Uterus _____ Cervix _____ Other _____ RECTAL Anus _____ Prostate _____ Hemorrhoids _____ Guaiac _____ Sphincter _____ Masses _____ BONES - JOINTS - MUSCLES Deformities _____ Tenderness _____ Swelling _____ Limit of Motion _____ Redness _____ Other _____ EXTREMITIES Color _____ Ulcers _____ Edema _____ Varicosities _____ Tremor _____ Other _____ Clubbing _____	
APPEARANCE Well _____ Vigorous _____ SKIN Color _____ Rash _____ Moisture _____ Nails _____ Texture _____ Nodules _____ Hair _____ Other _____ Ecchymosis _____ Petechiae _____ HEAD - EYES Conjunctiva _____ Pupil _____ Sclera _____ Ptosis _____ Movement _____ Lid-lag _____ Nystagmus _____ Other _____ Exophthalmos _____ EARS TM _____ Mastoid _____ Hearing _____ Other _____ Discharge _____		NOSE Airways _____ Sinus _____ Mucosa _____ Other _____ MOUTH Breath _____ Gums _____ Lips _____ Tongue _____ Teeth _____ Other _____ THROAT Tonsils _____ Uvula _____ Pharynx _____ Other _____ Palate _____ NECK Stiffness _____ Vessels _____ Masses _____ Trachea _____ Thyroid _____ Other _____ LYMPH NODES Cervical _____ Inguinal _____ Occipital _____ Epitrochlear _____ Auxillary _____ Other _____ Supraclavicular _____		ABDOMEN Sounds _____ Liver _____ Scars _____ Kidneys _____ Tenderness _____ Spleen _____ Masses _____ Hernia _____ Fluid _____ Rigidity _____ Other _____ GENITOURINARY - MALE Penis _____ Testes _____ Urethra _____ Prostate _____ Scrotum _____ Other _____	

Assessment/Plan: _____

OV Time: _____

Counseling: _____

☐ Risks, benefits, alternatives and plan reviewed and understood. ☐ Questions elicited/answered/understood ☐ Patient chart reviewed. ☐ Medications reviewed.

Lab / X-ray / Diagnostic Tests / Consultations: _____

Return: Physician: _____ Days _____ Weeks _____ Months

Appointment: _____

Nurse: _____ Days _____ Weeks _____ Months

Purpose: _____

Appointment: _____

Physician/Nurse Signature _____

VISIT QUESTIONNAIRE

Completing this form helps address your medical questions and concerns.

1. Reason for today's visit: ☐ routine follow-up ☐ new problem ☐ preventive care / annual check up

Please describe specific concerns related to today's visit:

2. Please list any doctor visits, tests, hospitalizations, medication changes, or other medical events since your last visit.

3. Are you having problems with: (____ check here if none apply)

- | | | | |
|---|--|--|---|
| ☐ Abuse | ☐ Depressed, down, or
hopeless | ☐ Lump / knot - specify
site _____ | ☐ Swallowing |
| ☐ Anxiety | ☐ Diarrhea | ☐ Medication side effects | ☐ Sweating |
| ☐ Appetite | ☐ Digestion | ☐ Menstruation | ☐ Swelling - specify site
_____ |
| ☐ Asthma | ☐ Discharge | ☐ Moles or spots | ☐ Trembling |
| ☐ Blackouts | ☐ Dizziness | ☐ Mood problems | ☐ Urination |
| ☐ Bleeding – specify site
_____ | ☐ Ear ache | ☐ Nausea | ☐ Vision |
| ☐ Blood pressure | ☐ Faintness | ☐ Numbness | ☐ Vomiting |
| ☐ Bowels | ☐ Fatigue | ☐ Pain – specify site
_____ | ☐ Walking |
| ☐ Breathing | ☐ Fever | ☐ Prostate | ☐ Weakness |
| ☐ Breasts/nipples | ☐ Forgetfulness | ☐ Rash | ☐ Weight loss / gain |
| ☐ Chest pain | ☐ Hearing | ☐ Sexual issues | ☐ Wheezing |
| ☐ Chills | ☐ Heart | ☐ Short of breath | ☐ Other _____ |
| ☐ Congestion | ☐ Heartburn | ☐ Skin | |
| ☐ Constipation | ☐ Little interest or
pleasure in doing
things | ☐ Sleep / Problems | |
| ☐ Cough / sneeze | | ☐ Snoring / Apnea | |

4. Please note other health concerns or questions you want to review with the doctor that are not otherwise addressed above.

5. In general, how do you feel? ☐ Very Good ☐ Good ☐ Average ☐ Bad ☐ Very Bad

6. How is your energy level? ☐ Very High ☐ High ☐ Average ☐ Low ☐ Very Low

7. How is your overall quality of life? ☐ Very Good ☐ Good ☐ Okay ☐ Bad ☐ Very Bad

8. Do you use: ☐ Tobacco ☐ Alcohol ☐ Non-prescribed drugs ☐ Alternative medicines

9. Do you regularly: ☐ Exercise ☐ Follow a healthy diet

10. Have you had the following check up:

Colon _____ Prostate _____ Mammogram _____ Pap Test _____

Check ☐ if there are any new health problems with family members (parents, siblings, children, aunts, uncles, etc.).

☐ if you are uncertain regarding your medications and their usage.

In addition to listing my concerns above, I will review as needed current Practice Information regarding my appointment and other services that may be provided today. I will update information including address, telephone and insurance information. I will provide Dr. Kelly with a list of my current medications.

Patient Signature _____

Date _____

Physician _____

06/2022