

# **Clinical Decision Support (CDS) Content and Health Level 7 (HL7)-Compliant Knowledge Artifacts (KNARTs)**

## **Primary Care: General Clinical Note - History and Physical Exam Clinical Content White Paper**

**Department of Veterans Affairs (VA)**



**Knowledge Based Systems (KBS)  
Office of Informatics and Information Governance (OIIG)  
Clinical Decision Support (CDS)**

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# **Clinical Decision Support (CDS) Content and Health Level 7 (HL7)-Compliant Knowledge Artifacts (KNARTs): Primary Care: General Clinical Note - History and Physical Exam Clinical Content White Paper**

by Department of Veterans Affairs (VA), , , , and

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**Table 1. Relevant KNART Information: Primary Care: General Clinical Note - History and Physical Exam**

Primary Care KNART	Associated CLIN
General Clinical Note - History and Physical Exam - Documentation Template	CLIN0009CA

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# Introduction

The VA is committed to improving the ability of clinicians to provide care for patients while increasing quality, safety, and efficiency. Recognizing the importance of standardizing clinical knowledge in support of this goal, VA is implementing the Health Level 7 (*HL7*) Knowledge Artifact Specification for a wide range of VA clinical use cases. Knowledge Artifacts, referred to as (*KNARTs*), enable the structuring and encoding of clinical knowledge so the knowledge can be integrated with electronic health records to enable clinical decision support.

The purpose of this Clinical Content White Paper (*CCWP*) is to capture the clinical context and intent of *KNART* use cases in sufficient detail to provide the *KNART* authoring team with the clinical source material to construct the corresponding knowledge artifacts using the *HL7* Knowledge Artifact Specification. This paper has been developed using material from a variety of sources: VA artifacts, clinical practice guidelines, evidence in the body of medical literature, and clinical expertise. After reviewing these sources, the material has been synthesized and harmonized under the guidance of VA subject matter experts to reflect clinical intent for this use case.

Unless otherwise noted, items within this white paper (e.g., documentation template fields, orderable items, etc.) are chosen to reflect the clinical intent at the time of creation. To provide an exhaustive list of all possible items and their variations is beyond the scope of this work.

---

# Conventions Used

Conventions used within the knowledge artifact descriptions include:

*<obtain>*: Indicates a prompt to obtain the information listed

- If possible, the requested information should be obtained from the underlying system(s). Otherwise, prompting the user for information may be required
- The technical and clinical comments associated with a section should be consulted for specific constraints on the information (e.g., time-frame, patient interview, etc.)
- Default Values: Unless otherwise noted, *<obtain>* indicates to obtain the most recent observation. It is recognized that this default time-frame value may be altered by future implementations

*[...]*: Square brackets enclose explanatory text that indicates some action on the part of the clinical user, or general guidance to the clinical or technical teams. Examples include, but are not limited to:

*[Begin ...], [End ...]*: Indicates the start and end of specific areas to clearly delineate them for technical purposes.

*[Activate ...]*: Initiates another knowledge artifact or knowledge artifact section.

*[Section Prompt: ...]*: If this section is applicable, then the following prompt should be displayed to the user.

*[Section Selection Behavior: ...]*: Indicates technical constraints or considerations for the selection of items outlined in the section prompt.

*[Attach: ...]*: Indicates that the specified item (e.g. procedure or result interpretation) should be attached to the documentation template if available.

*[Link: ...]*: Indicates that rather than attaching an item (e.g. image), a link should be included in the documentation template.

*[Clinical Comment: ...]*: Indicates clinical rationale or guidance.

*[Technical Note: ...]*: Indicates technical considerations or notes to be utilized for KNART authoring and at time of implementation planning.

*[If ...]*: Indicates the beginning of a conditional section.

*[Else, ...]*: Indicates the beginning of the alternative branch of a conditional section.

*[End if ...]*: Indicates the end of a conditional section.

*[Check box]*: Indicates items that should be selected based upon the section selection behavior.

---

# **Chapter 1. Primary Care: General Clinical Note - History and Physical Exam**

## **Clinical Context**

[Begin Clinical Context.]

Capturing clinical information in a structured format greatly enhances its utility as a knowledge object. Applying such an approach to previously unstructured data, such as miscellaneous notes, will greatly increase its value.

**Table 1.1. Clinical Context Domains**

Target User	Primary Care Clinical providers
Patient	Adult Outpatients
Priority	Routine
Specialty	Primary Care
Location	Outpatient

[End Clinical Context.]

## **Knowledge Artifacts**

[Begin Knowledge Artifacts.]

This section describes the CDS knowledge artifact that is intended to facilitate documentation of information obtained during an initial primary care new patient visit. The documentation template includes the following sections: Chief complaint, history of present illness, review of systems, sexual assault, annual screening questionnaire, and health literacy assessment.

The knowledge artifact which defines this clinical use case is described in detail in the following sections:

Documentation Template: Primary Care: General Clinical Note - History and Physical Exam NART

Documents the information obtained during initial primary care new patient visit

Includes logic for appropriate display of documentation sections

[End Knowledge Artifacts.]

---

# **Chapter 2. Primary Care: General Clinical Note - History and Physical Exam Documentation Template**

[Begin Primary Care: General Clinical Note - History and Physical Exam Documentation Template.]

## **Knowledge Narrative**

[Begin Knowledge Narrative.]

[See Clinical Context in Chapter 1.]

[Technical Note: The Documentation template shall:

Allow for the efficient documentation of a general clinical note during initial patient evaluation; and

Adjust content presented to the clinician as needed during the evaluation; and

Pre-populate with existing data from the patient's medical record for review and editing by the end-user.]

[End Knowledge Narrative.]

## **General Clinical Note**

[Technical Note: The template will be structured as follows.]

### **Demographics**

[Begin Demographics.]

[Section Prompt: Demographics.]

<obtain> Patient Name

<obtain> Medical Record Number

<obtain> Attending Physician

<obtain> Other Current Clinical Providers

<obtain> Mental Health Providers

<obtain> Social Workers

<obtain> Residents (Include If Current)

<obtain> Other Providers

<obtain> Date of Birth

<obtain> Age (Years)

<obtain> Sex

<obtain> Self-Reported Gender Identity

<obtain> Race/Ethnicity

<obtain> Preferred Language

[Section Prompt: Translator Needed.]

[Section Selection Behavior: Select only one. Required.]

Yes

No

[End Demographics.]

## History

[Begin History.]

[Technical Note: The template will provide links to other targeted KNARTs where additional detail is needed.]

[Technical Note: Any information that can be obtained from the system should pre-populate the section fields in a manner that is apparent to the end user.]

[Technical Note: Any automatically obtained data should be editable by the user of the KNART.]

[Technical Note: The ability for the end user to enter multiples is necessary to be built during authoring.]

[Section Prompt: Visit Reason/Chief Complaint.]

- <obtain> Description

[Section Prompt: History of Present Illness.]

<obtain> Details of history of present illness

### Past Medical History

[Section Prompt: Past Medical History.]

<obtain> Past Medical History

### Surgical History

[Section Prompt: Surgical History.]

[Technical Note: Allow for multiple entry.]

<obtain> Surgical Procedure

<obtain> Surgical Date

### Mental Health History

[Section Prompt: Mental Health History]

[Technical Note: Link to future Mental Health History KNART.]

[Section Prompt: Are you currently seeing someone or taking medication for stress-related concerns, or for a mental health concern such as Post-Traumatic Stress Disorder (PTSD)?]

<obtain> Current Behavioral Health Condition and Treatment History

**Primary Care: General Clinical  
Note - History and Physical  
Exam Documentation Template**

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[Section Prompt: Have you ever received treatment (such as medication or counseling) for a stress-related concern, or for a mental health concern such as PTSD?]

<obtain>Past Behavioral Health Condition and Treatment History

[Section Prompt: Have you ever been to the Emergency Room or have you ever been hospitalized for a stress-related concern, or mental health concern such as PTSD?]

<obtain>Emergency Room or Hospital Behavioral Health Condition and Treatment History

### **Military History**

[Section Prompt: Military History.]

[Technical Note: Please enable entry of multiple instances of “Military occupation”, “Separation from service date” and “Branch of service”]

<obtain> Military occupation

<obtain> Military Exposure (Agent Orange, etc.)

<obtain> Years of Service

<obtain> Separation from service date

<obtain> Branch of Service

<obtain> Overseas Travel

<obtain> Conflict History

<obtain> Additional Details

### **Medication History**

[Section Prompt: Medication History.]

[Technical Note: Link to future Medication Reconciliation KNART.]

[Technical Note: “Recently Expired Medications” is defined in the VA’s “ESSENTIAL MEDICATION INFORMATION STANDARDS” directive as “within the past 90 to 120 days”. The directive is located at: [http://www.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=3119](http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3119) (follow the links in Appendix A).]

<obtain> Current Prescribed Medications

<obtain> Current Over-the-Counter (OTC) Medications

[Technical Note: The following field should be completed automatically.]

<obtain> Recently Expired Medications

### **Allergies and Adverse Reactions**

[Section Prompt: Allergies and Adverse Reactions.]

<obtain> Allergies and Adverse Reactions

### **Family Medical History**

[Section Prompt: Family Medical History.]

[Technical Note: Link to Family Health History KNART.]

<obtain> Family Medical History

### **Preventative Services History**

[Section Prompt: Preventative Services History.]

[Technical Note: Provide the following links to the user of this KNART: <https://www.medicare.gov/coverage/preventive-and-screening-services.html>; <https://www.prevention.va.gov/>; [https://www.prevention.va.gov/Healthy\\_Living/Get\\_Recommended\\_Screening\\_Tests\\_and\\_Immunizations\\_for\\_Men.asp](https://www.prevention.va.gov/Healthy_Living/Get_Recommended_Screening_Tests_and_Immunizations_for_Men.asp); [https://www.prevention.va.gov/Healthy\\_Living/Get\\_Recommended\\_Screening\\_Tests\\_and\\_Immunizations\\_for\\_Women.asp](https://www.prevention.va.gov/Healthy_Living/Get_Recommended_Screening_Tests_and_Immunizations_for_Women.asp)] [[https://www.prevention.va.gov/Healthy\\_Living/Get\\_Recommended\\_Screening\\_Tests\\_and\\_Immunizations\\_for\\_Women.asp](https://www.prevention.va.gov/Healthy_Living/Get_Recommended_Screening_Tests_and_Immunizations_for_Women.asp)]

<obtain> Preventative Services History

### **Personal and Social History**

[Section Prompt: Living Situation/Social Support/Financial Support.]

<obtain> Living Situation

<obtain> Marital Status/Domestic Status

<obtain> Current Occupation

<obtain> Level of Education

<obtain> Additional Personal, Social, and Employment History

[Section Prompt: Substance Use.]

<obtain> Alcohol

<obtain> Tobacco

<obtain> Illicit drug(s)

[Section Prompt: Sexual and Abuse History.]

<obtain> Sexual Activity

<obtain> Sexual Assault/Abuse History

<obtain> Military Sexual Trauma History

<obtain> Physical or Other Assault/Abuse History

[Section Prompt: Disability Rating.]

<obtain> Military disability % rating and associated service connected conditions.

### **Review of Systems**

[Section Prompt: Review of Systems.]

[Section Prompt: Complete only relevant sections if complete history and physical not intended.]

[Technical Note: Link to Review of Systems KNART (not currently available).]

<obtain> Constitutional Symptoms (for example, fever, weight loss)

<obtain> Eyes

<obtain> Ears, nose, mouth, throat

<obtain> Cardiovascular

<obtain> Respiratory

<obtain> Gastrointestinal

<obtain> Genitourinary

<obtain> Musculoskeletal

<obtain> Integumentary (skin and/or breast)

<obtain> Neurological

<obtain> Psychiatric

<obtain> Endocrine

<obtain> Hematologic/Lymphatic

<obtain> Allergic/Immunologic

[End History.]

## Screening

[Begin Screening.]

[Technical Note: The template will provide links to other targeted KNARTs where additional detail is needed.]

[Screen Prompt: Screening.]

<obtain> Health Literacy

<obtain> Cognition

<obtain> Self-Reported Health Rating

<obtain> Nutrition/Diet

<obtain> Exercise/Physical Activity

[Technical Note: Link to Clinical Reminder for alcohol use screening if there is one available.]

<obtain> Alcohol Use

[Technical Note: Link to Tobacco Assessment and Cessation Counseling KNART.]

<obtain> Tobacco Use

<obtain> Substance Use (Including Prescription Drugs)

[Technical Note: Link to Consult for Depression and Suicide Risk Assessment KNARTs.]

<obtain> Consult for Depression

<obtain> Suicide Risk Assessment

[Technical Note: Link to PTSD Screening and Assessment and Suicide Risk Assessment KNARTs.]

---

<obtain> PTSD history

<obtain> Suicide Risk Assessment

[Clinical Comment: Scale is 0-10 for the pain instrument below.]

<obtain> Pain Level (0-10)

[Section Prompt: Functional Assessment.]

[Technical Note: Provide user a link to the Katz Index of ADLs and Lawton-Brody Instrumental Activities of Daily Living scale: [https://clas.uiowa.edu/socialwork/sites/clas.uiowa.edu.socialwork/files/NursingHomeResource/documents/Katz%20ADL\\_LawtonIADL.pdf](https://clas.uiowa.edu/socialwork/sites/clas.uiowa.edu.socialwork/files/NursingHomeResource/documents/Katz%20ADL_LawtonIADL.pdf)

<obtain> Safety (Including Fall Risk, If Appropriate)

<obtain> Additional Risk Factors

[Section Prompt: Advance Directive Confirmed Accessible to Providers.]

Yes

<obtain> Additional Details

No

[End Screening.]

## Physical Examination

[Begin Physical Examination.]

[Section Prompt: Vital Signs.]

[Technical Note: Any information that can be obtained from the system should pre-populate the section fields in a manner that is apparent to the end user.]

<obtain> Systolic Blood Pressure (BP) (mm Hg)

<obtain> Diastolic BP (mm Hg)

<obtain> Temperature (°F)

<obtain> Heart Rate beats per minutes (bpm)

<obtain> Respiratory rate breaths per minute

<obtain> Oxygen Saturation (%)

<obtain> Height (Inches)

<obtain> Weight (Pounds)

[Technical Note: Body mass index (BMI) should be calculated and provided below, in kilograms per square meter ( $\text{kg}/\text{m}^2$ ), using the formula  $\text{BMI} = 703 \times \text{weight} (\text{pounds})/\text{height} (\text{inches})^2$ .]

<obtain> Body Mass Index ( $\text{kg}/\text{m}^2$ )

<obtain> Waist Circumference (Centimeters)

[Section Prompt: Physical Exam.]

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<obtain> Head, Eyes, Ears, Nose, Throat (HEENT) Exam

<obtain> Neck Exam

<obtain> Cardiovascular Exam

<obtain> Pulmonary Exam

<obtain> Abdominal Exam

<obtain> Genitourinary Exam

<obtain> Extremities Exam

<obtain> Musculoskeletal Exam

<obtain> Skin Exam

<obtain> Neurological Exam

[Section Prompt: Laboratory Results.]

[Technical Note: The following field should be completed automatically if results are available.]

[Technical Note: Provide access to all lab data, with ability to filter by lab type or date.]

<obtain> Laboratory Test Results

[Section Prompt: Imaging Results.]

[Technical Note: Images should be attached automatically if text is provided for the following field.]

[Technical Note: Provide access to all images, with ability to filter by image type or date.]

<obtain> Imaging Study Reports

<link> Image

[End Physical Examination.]

## **Assessment and Plan**

[Begin Assessment.]

[Section Prompt: Assessment.]

<obtain> Details

Assessments and Plan, Including Risks and Benefits of Recommended Treatment, Discussed with Patient

[End Assessment.]

[Begin Plan.]

<obtain> Plan of Treatment

<obtain> Preventive Services

[Technical Note: Provide links to:

National Center for Health Promotion and Disease Prevention's Get Recommended Screening Tests and Immunizations for Men [https://www.prevention.va.gov/Healthy\_Living/Get\_Recommended\_Screening\_Tests\_and\_Immunizations\_for\_Men.asp]

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Get Recommended Screening Tests and Immunizations for Women [[https://www.prevention.va.gov/Healthy\\_Living/Get\\_Recommended\\_Screening\\_Tests\\_and\\_Immunizations\\_for\\_Women.asp](https://www.prevention.va.gov/Healthy_Living/Get_Recommended_Screening_Tests_and_Immunizations_for_Women.asp)]

U.S. Preventive Services Task Force's (USPSTF) A and B Recommendations [<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations>]]

<obtain> Preventive Counseling

<obtain> Patient Education

[Technical Note: Provide link [www.veteranshealthlibrary.org](http://www.veteranshealthlibrary.org) [<http://www.veteranshealthlibrary.org>]]

<obtain> Self-Management Education

[Section Prompt: Medications Plan.]

<obtain> CurrentMedications

Continue Medications

<obtain> Continued Medications

Discontinue Medications

<obtain> Discontinued Medications

[Technical Note: If either of the following – "Modified Medications" or "New Medications" – are selected, the clinician should be able to select and attach relevant order sets.]

Modified Medications

<obtain> Modified Medications

New Medications

<obtain> New Medications

[Technical Note: Provide link to Medication Reconciliation KNART as available.]

<obtain> Other Plans

[Section Prompt: Consultations?]

<obtain> Consultations

<obtain> Consult specifics

[Section Prompt: Next Visit?]

<obtain> Next visit date

Labs/imaging results were reviewed with the patient.

Patient Expresses Understanding and Agrees with Plan

[End Plan.]

[End Primary Care: General Clinical Note - History and Physical Exam Documentation Template.]

---

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# Appendix A. Existing Sample VA Artifacts

The following artifacts are from the VA National Primary Care Note Template.

**Figure A.1. VA National Primary Care Note Template: VA Primary Care New Patient - Visit/Chief Complaint and Past History Sections**

Template: VA PC New Patient

REASON FOR VISIT/CHIEF COMPLAINT:  
(Describe symptom, problem, condition, diagnosis in patient's words if possible)  
 Acute problem(s)  Chronic problem(s)  Health maintenance  
 Related to MVA/Accident  Work-related

(HPI: include location, quality, severity, duration, modifying factors & associated signs/symptoms)

SOURCE(S) OF HISTORY:  Patient  Family  Outside records  VA records  Unobtainable  
(If history obtained from family member, specify which family member)  
(If unobtainable, specify reason such as coma, dementia, aphasia, psychosis)

PAST HISTORY:

ADULT ILLNESS:  HTN  Diabetes  CAD/IHD  Hyperlipidemia  CVA

CHILDHOOD ILLNESS:

SURGERIES

INJURIES:

FEMALE GENDER SPECIFIC HISTORY:  
AGE AT MENARCHE: \_\_\_\_\_  
DATE LAST MENSTRUAL PERIOD: \_\_\_\_\_  
DESCRIBE MENSES:  
BIRTH CONTROL:  None  Pill  Diaphragm  
PREGNANCIES/MISCARRIAGES/ABORTIONS:

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.2. VA National Primary Care Note Template: VA Primary Care New Patient - Female Gender Specific History and Social History Section**

**Template: VA PC New Patient**

**FEMALE GENDER SPECIFIC HISTORY:**

AGE AT MENARCHE: \_\_\_\_\_

DATE LAST MENSTRUAL PERIOD: \_\_\_\_\_

DESCRIBE MENSES: \_\_\_\_\_

BIRTH CONTROL:  None  Pill  Diaphragm

PREGNANCIES/MISCARRIAGES/ABORTIONS:

Number of full term pregnancies: \_\_\_\_\_

Number of spontaneous abortions: \_\_\_\_\_

Number of therapeutic abortions: \_\_\_\_\_

Number of other types Abortions: \_\_\_\_\_

Age at first pregnancy: \_\_\_\_\_

DATE LAST PAP SMEAR: \_\_\_\_\_ RESULTS: \_\_\_\_\_

DATE LAST MAMMOGRAM: \_\_\_\_\_ RESULTS: \_\_\_\_\_

**SOCIAL HISTORY: (HABITS/MARITAL STATUS/MISC)**

HABITS: (If pt drinks, indicate amount by clicking first down arrow.  
If past hx of alcohol abuse or currently enrolled in alcohol  
program click second down arrow)

ALCOHOL?  No alcohol in past year  (+) Alcohol use

TOBACCO?  Lifelong Non-user.  Ex-tobacco user  Current user.

ILLICIT DRUGS?  Never used.  Past user.  Present user.

(Select to add additional text)

MARITAL/DOMESTIC STATUS:  
Living arrangements:   
 Married.  Widowed.  Divorced.  Single.  Separated.  Other (give details): \_\_\_\_\_

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.3. VA National Primary Care Note Template: VA Primary Care New Patient - Marital/Domestic Status Section**

**Template: VA PC New Patient**

MARITAL/DOMESTIC STATUS:

Living arrangements:

Married.  Widowed.  with spouse/partner  
 with children  
 with parents  
 with extended family  
 with friend/caregiver  
 alone  
 residential living facility  
 nursing home  
 homeless  
 other:

OTHER: (Include: Education, Work, Social, etc.)  Other (give details):  
 habits, etc.)

(SOCIAL HISTORY - MILITARY/SEX)

ALLERGIES AS DISPLAYED IN VISTA:  
 SULFA-GYN, LORAZEPAM, SULFABENZAMIDE/SULFACETAMIDE/SULFHIAZOLE, IODINE, LATEX  
 TERAZOSIN, DIPHENHYDRAMINE 12.5MG/5ML ELX, TAPE, CHOCOLATE, ORANGE JUICE  
 POWDER FREE GLOVES, SEAFOOD, PENICILLIN, PLASTIC TAPE, VASELINE, GOLDENROD  
 SKELAKIN 800MG TAB, BUTTER, ACTIVASE, AMOXICILLIN, DOCUSATE/MINERAL OIL, MANGOS  
 GREEN BELL PEPPERS, HAIR SPRAY, MILK, LUBRICANT, VAGINAL, SHELLFISH, CURRY  
 MAYONNAISE, HONEY BEE STINGS, GREEN TEA, MUSTARD, STRAWBERRIES, SIMVASTATIN  
 FOOD DYES, MORPHINE, HEPARIN, APPLE CIDER VINEGAR, ASPIRIN RELATED MEDICATIONS  
 IBUPROFEN/PSEUDOEPHEDRINE, BEE STINGS, DUST  
 (Inquire about any changes since Vista was last updated.)

Patient/family state(s):  No new allergies  (+) New allergies:

MEDICATIONS (as listed in Vista):  
 Active Outpatient Medications (excluding Supplies):

Active Outpatient Medications	Status
1) ACETAMINOPHEN 325MG TAB TAKE ONE TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN	ACTIVE
2) CIMETIDINE 400MG TAB TAKE ONE TABLET BY MOUTH TWICE A DAY BEFORE MEALS AS NEEDED FOR STOMACH ACID	ACTIVE

OTC OR NON-VA PRESCRIPTION MEDICATIONS: (List OTC meds, herbals, vitamins & ASA)

\* Indicates a Required Field

**Figure A.4. VA National Primary Care Note Template: VA Primary Care New Patient - Marital/Domestic Status, Social History and Military History (Branch of Service)**

**Template: VA PC New Patient**

MARITAL/DOMESTIC STATUS:  
 Living arrangements:  
 Married.  Widowed.  Divorced.  Single.  Separated.  Other (give details):  
 \_\_\_\_\_

OTHER: (Include: Education, Occupation, Travel hx, Exercise habits, etc.)  
 \_\_\_\_\_

(SOCIAL HISTORY - MILITARY/SEXUAL/ABUSE)

MILITARY HISTORY:  
 BRANCH OF SERVICE:   
 PERIOD OF SERVICE:   
 SPECIFIC YEARS OF SERVICE:   
 ENVIRONMENTAL EXPOSURE:   
 Was patient a POW? -  Yes  No  
 \_\_\_\_\_

SEXUALLY ACTIVE?  Yes  No  
 (Comment on: Preference, multiple partners, use of protection, etc.)

SCREEN FOR PHYSICAL/PSYCHOLOGICAL/SEXUAL ABUSE:  
 (If patient reports abuse click on down arrow and indicate type of abuse)  
 Denies abuse  Reports abuse: (Type of abuse:)   
 Past abuse  Recent abuse  Ongoing abuse

ALLERGIES AS DISPLAYED IN VISTA:  
 SULFA-GYN, LORAZEPAM, SULFABENZAMIDE/SULFACETAMIDE/SULFATHIAZOLE, IODINE, LATEX  
 TERAZOSIN, DIPHENHYDRAMINE 12.5MG/5ML ELX, TAPE, CHOCOLATE, ORANGE JUICE  
 POWDER FREE GLOVES, SEAFOOD, PENICILLIN, PLASTIC TAPE, VASELINE, GOLDENROD  
 SKELAXIN 800MG TAB, BUTTER, ACTIVASE, AMOXICILLIN, DOCUSATE/MINERAL OIL, MANGOS  
 GREEN BELL PEPPERS, HAIR SPRAY, MILK, LUBRICANT, VAGINAL, SHELLFISH, CURRY  
 MAYONNAISE HONEY RRF STINGS GREEN TEA MUSTARD STRAWBERRIES STIMVASTATIN

\* Indicates a Required Field

**Figure A.5. VA National Primary Care Note Template: VA Primary Care New Patient - Marital/Domestic Status, Social History and Military History Sections (Period of Service)**

**Template: VA PC New Patient**

MARITAL/DOMESTIC STATUS:  
Living arrangements:  
 Married.  Widowed.  Divorced.  Single.  Separated.  Other (give details):  
  
 OTHER: (Include: Education, Occupation, Travel hx, Exercise habits, etc.)

(SOCIAL HISTORY - MILITARY/SEXUAL/ABUSE)

MILITARY HISTORY:  
BRANCH OF SERVICE: Was patient a POW? -  Yes  No  
PERIOD OF SERVICE: SPECIFIC YEARS OF SERVICE: WWII (Dec 1941-Dec 1946)  
ENVIRONMENTAL EXPOSURE: Korean War (July 1950-January 1955)  
Vietnam era (Aug 1964-April 1975)  
Persian Gulf (Aug 1990- )  
Other

SEXUALLY ACTIVE?  Yes  No  
(Comment on: Preference, multiple partners, use of protection, etc.)

SCREEN FOR PHYSICAL/PSYCHOLOGICAL/SEXUAL ABUSE:  
(If patient reports abuse click on down arrow and indicate type of abuse)  
 Denies abuse  Reports abuse: (Type of abuse:)   
 Past abuse  Recent abuse  Ongoing abuse

ALLERGIES AS DISPLAYED IN VISTA:  
SULFA-GYN, LORAZEPAM, SULFABENZAMIDE/SULFACETAMIDE/SULFATHIAZOLE, IODINE, LATEX  
TERAZOSIN, DIPHENHYDRAMINE 12.5MG/5ML ELX, TAPE, CHOCOLATE, ORANGE JUICE  
POWDER FREE GLOVES, SEAFOOD, PENICILLIN, PLASTIC TAPE, VASELINE, GOLDENROD  
SKELAKIN 800MG TAB, BUTTER, ACTIVASE, AMOXICILLIN, DOCUSATE/MINERAL OIL, MANGOS  
GREEN BELL PEPPERS, HAIR SPRAY, MILK, LUBRICANT, VAGINAL, SHELLFISH, CURRY  
MAYONNAISE HONEY RRF STINGS GREEN TEA MUSTARD STRAWBERRIES STIVUASTATIN

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.6. VA National Primary Care Note Template: VA Primary Care New Patient - Marital/Domestic Status, Social History, Military History and Screen for Physical/Psychological/Sexual Abuse Sections**

**Template: VA PC New Patient**

MARITAL/DOMESTIC STATUS:  
 Living arrangements:   
 Married.  Widowed.  Divorced.  Single.  Separated.  Other (give details):

OTHER: (Include: Education, Occupation, Travel hx, Exercise habits, etc.)

(SOCIAL HISTORY - MILITARY/SEXUAL/ABUSE)

MILITARY HISTORY:  
 BRANCH OF SERVICE:  Was patient a POW? -  Yes  No  
 PERIOD OF SERVICE:   
 SPECIFIC YEARS OF SERVICE   
 ENVIRONMENTAL EXPOSURE:

SEXUALLY ACTIVE?  Yes  No  
 (Comment on: Preference, multiple partners, use of protection, etc.)

SCREEN FOR PHYSICAL/PSYCHOLOGICAL/SEXUAL ABUSE:  
 (If patient reports abuse click on down arrow and indicate type of abuse)  
 Denies abuse  Reports abuse: (Type of abuse:)   
 Past abuse  Recent  abuse  
 physical  
 psychological  
 sexual

ALLERGIES AS DISPLAYED IN VISTA:  
 SULFA-GYN, LORAZEPAM, SULFABENZAMIDE/SULFACETAMIDE/SULFATHIAZOLE, IODINE, LATEX  
 TERAZOSIN, DIPHENHYDRAMINE 12.5MG/5ML ELX, TAPE, CHOCOLATE, ORANGE JUICE  
 POWDER FREE GLOVES, SEAFOOD, PENICILLIN, PLASTIC TAPE, VASELINE, GOLDENROD  
 SKELAXIN 800MG TAB, BUTTER, ACTIVASE, AMOKICILLIN, DOCUSATE/MINERAL OIL, MANGOS  
 GREEN BELL PEPPERS, HAIR SPRAY, MILK, LUBRICANT, VAGINAL, SHELLFISH, CURRY  
 MAYONNAISE HONEY BEE STINGS GREEN TEA MUSTARD STRAWBERRIES STIMVASTATIN

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.7. VA National Primary Care Note Template: VA Primary Care New Patient - Allergies as Displayed in VistA, Medications, Over the Counter (OTC) or Non-VA Prescription Medications, and Family History Sections**

Template: VA PC New Patient

ALLERGIES AS DISPLAYED IN VISTA:  
 SULFA-GYN, LORAZEPAM, SULFABENZAMIDE/SULFACETAMIDE/SULFATHIAZOLE, IODINE, LATEX  
 TERAZOSIN, DIPHENHYDRAMINE 12.5MG/5ML ELK, TAPE, CHOCOLATE, ORANGE JUICE  
 POWDER FREE GLOVES, SEAFOOD, PENICILLIN, PLASTIC TAPE, VASELINE, GOLDENROD  
 SKELAXIN 800MG TAB, BUTTER, ACTIVASE, AMOXICILLIN, DOCUSATE/MINERAL OIL, MANGOS  
 GREEN BELL PEPPERS, HAIR SPRAY, MILK, LUBRICANT, VAGINAL, SHELLFISH, CURRY  
 MAYONNAISE, HONEY BEE STINGS, GREEN TEA, MUSTARD, STRAWBERRIES, SIMVASTATIN  
 FOOD DYES, MORPHINE, HEPARIN, APPLE CIDER VINEGAR, ASPIRIN RELATED MEDICATIONS  
 IBUPROFEN/PSEUDOEPHEDRINE, BEE STINGS, DUST  
 (Inquire about any changes since VISTA was last updated.)  
 Patient/family state(s):  No new allergies  (+) New allergies:

MEDICATIONS (as listed in Vista):  
 Active Outpatient Medications (excluding Supplies):

Active Outpatient Medications	Status
1) ACETAMINOPHEN 325MG TAB TAKE ONE TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN	ACTIVE
2) CIMETIDINE 400MG TAB TAKE ONE TABLET BY MOUTH TWICE A DAY BEFORE MEALS AS NEEDED FOR STOMACH ACID	ACTIVE

OTC OR NON-VA PRESCRIPTION MEDICATIONS: (List OTC meds, herbals, vitamins & ASA)

FAMILY HISTORY: (Include pertinent family history. Inquire about family hx of colorectal cancer, gender specific cancers, DM, CAD/IHD)

REVIEW OF SYSTEMS (Include at least ONE system from one of the following: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Skin/Hair, Neuro, Psych, Endocrine, Hematologic/Lymphatic, Allergy/Immune System)

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.8. VA National Primary Care Note Template: VA Primary Care New Patient - Review of Systems Section**

Template: VA PC New Patient

REVIEW OF SYSTEMS (Include at least ONE system from one of the following: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Skin/Hair, Neuro, Psych, Endocrine, Hematologic/Lymphatic, Allergy/Immune System)

(Click here for expanded point and click format) Review of Systems

Constitutional:

(+) Positive symptoms reported:

- Fevers, chills, weakness, nights sweats and weight change
- Fevers
- Chills
- Weakness
- Night Sweats
- Weight loss (unintentional)
- Weight gain (unintentional)

(-) Negative for:

Fevers, chills, weakness, nights sweats and weight change

Fevers

Chills

Weakness

Night Sweats

Weight loss (unintentional)

Weight gain (unintentional)

Eyes:

Ears:

Nose:

Mouth/Dental:

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.9. VA National Primary Care Note Template: VA Primary Care New Patient - Review of Systems, Eyes Negative for Symptoms Section**

Template: VA PC New Patient

REVIEW OF SYSTEMS (Include at least ONE system from one of the following: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Skin/Hair, Neuro, Psych, Endocrine, Hematologic/ Lymphatic, Allergy/Immune System)

(Click here for expanded point and click format) Review of Systems

Constitutional:

Eyes:

(+) Positive symptoms reported:

eye pain, blurred vision, double vision  
 eye pain  
 vision change  
 double vision  
 blurred vision

problems reading  
 problems distance vision  
 night problems

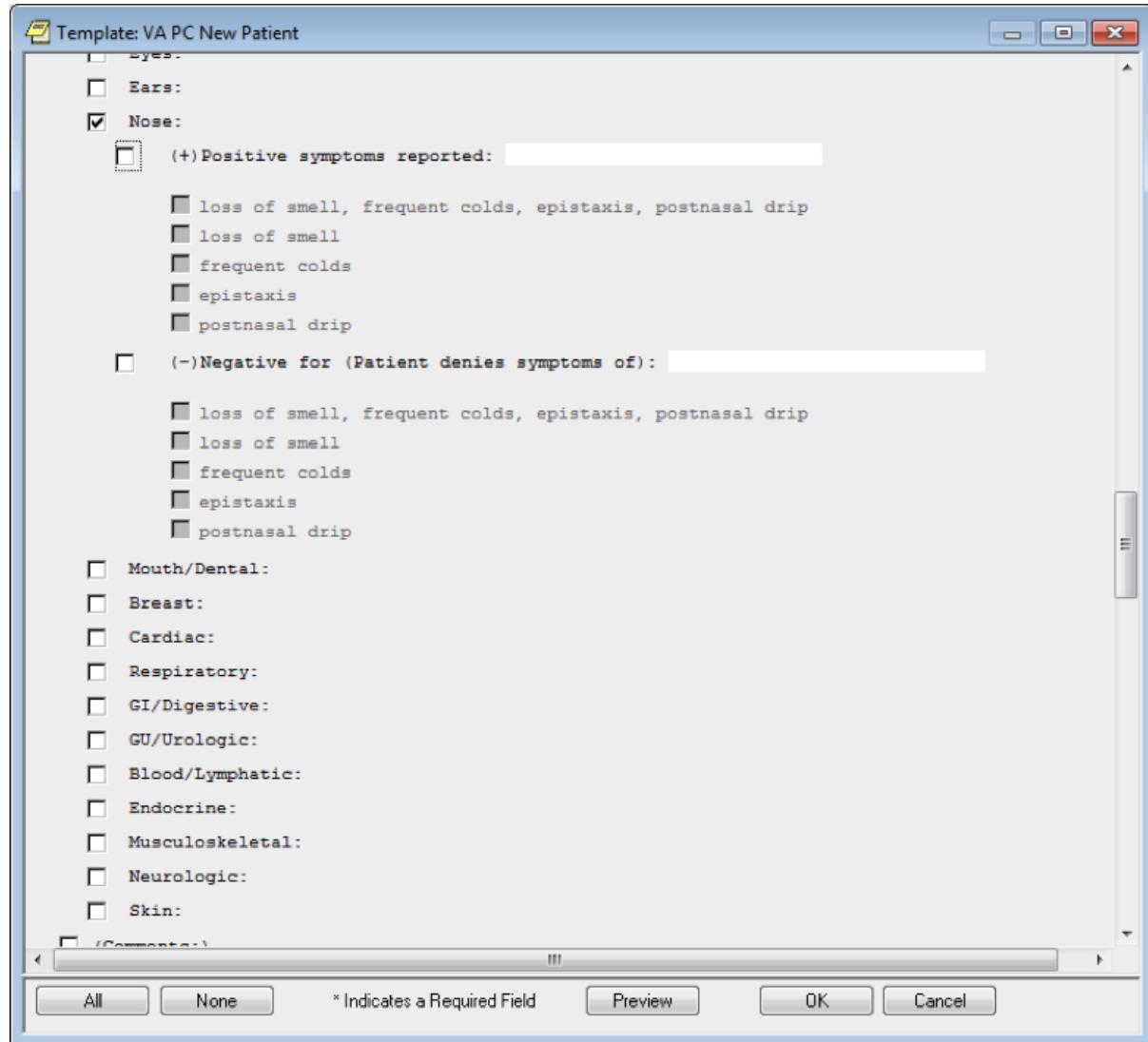
(-)Negative for (Patient denies symptoms of):

eye pain, blurred vision, double vision  
 eye pain  
 vision change  
 double vision  
 blurred vision

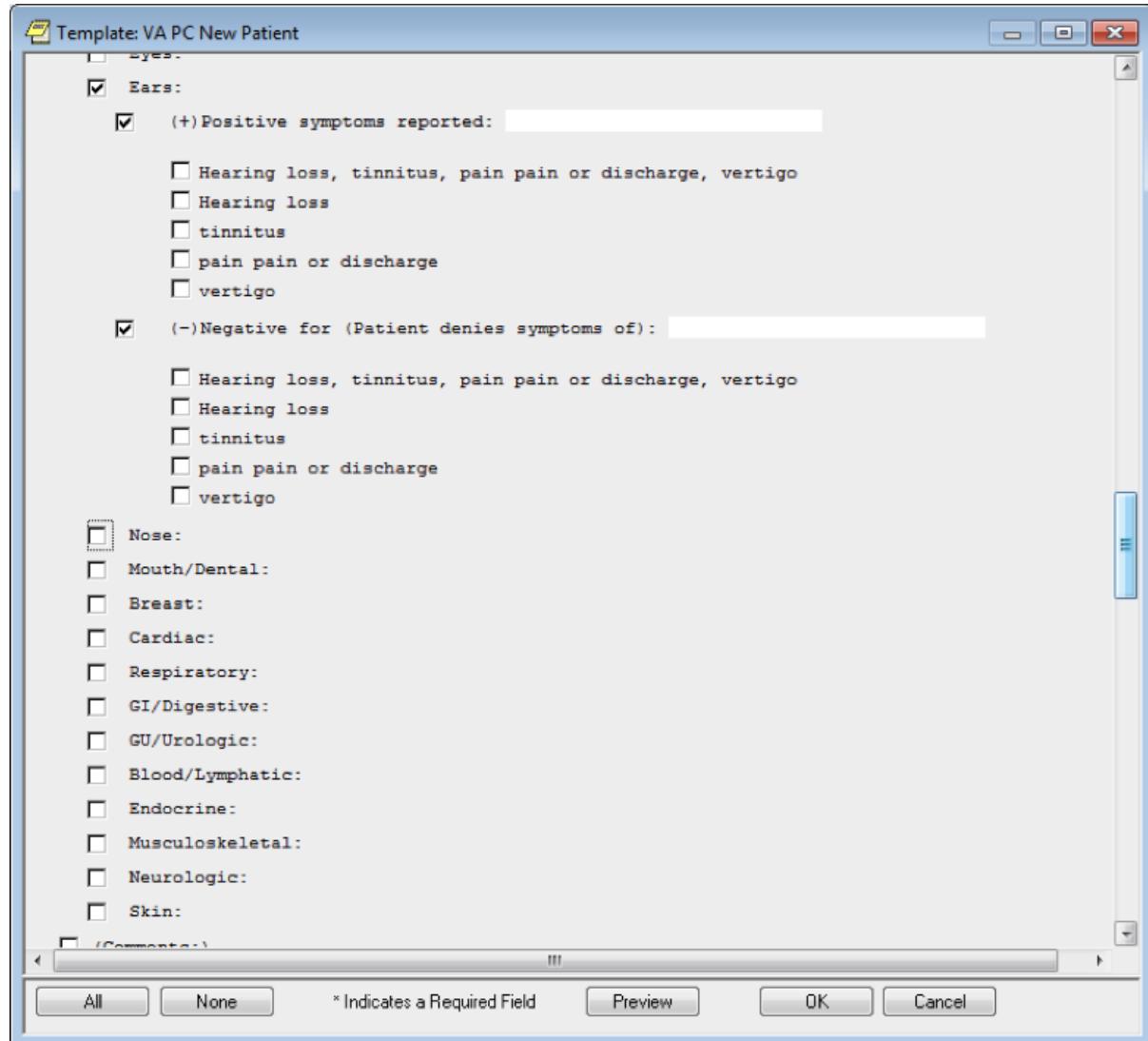
problems reading  
 problems distance vision  
 night problems

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.10. VA National Primary Care Note Template: VA Primary Care New Patient - Nose Positive Symptoms Reported Section**



**Figure A.11. VA National Primary Care Note Template: VA Primary Care New Patient - Ears with Positive Symptoms Reported and Negative for Symptoms Sections**



**Figure A.12. VA National Primary Care Note Template: VA Primary Care New Patient - Mouth/Dental Section**

Template: VA PC New Patient

Eyes:  
 Ears:  
 Nose:  
 Mouth/Dental:  
 (+) Positive symptoms reported: \_\_\_\_\_  
 sores, bleeding gums, hoarseness, dentures, change in taste  
 sores  
 bleeding gums  
 hoarseness  
 dentures  
 change in taste  
 (-) Negative for (Patient denies symptoms of): \_\_\_\_\_  
 sores, bleeding gums, hoarseness, dentures, change in taste  
 sores  
 bleeding gums  
 hoarseness  
 dentures  
 change in taste

Breast:  
 Cardiac:  
 Respiratory:  
 GI/Digestive:  
 GU/Urologic:  
 Blood/Lymphatic:  
 Endocrine:  
 Musculoskeletal:  
 Neurologic:

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.13. VA National Primary Care Note Template: VA Primary Care New Patient - Breast Section**

Template: VA PC New Patient

Eyes:  
 Ears:  
 Nose:  
 Mouth/Dental:  
 Breast:  
 (+) Positive symptoms reported: \_\_\_\_\_  
 masses, discharge  
 masses  
 discharge  
 (-) Negative for (Patient denies symptoms of): \_\_\_\_\_  
 masses, discharge  
 masses  
 discharge  
 Cardiac:  
 Respiratory:  
 GI/Digestive:  
 GU/Urologic:  
 Blood/Lymphatic:  
 Endocrine:  
 Musculoskeletal:  
 Neurologic:  
 Skin:  
 (Comments:)

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.14. VA National Primary Care Note Template: VA Primary Care New Patient - Cardiac Section**

Template: VA PC New Patient

Eyes:  
 Ears:  
 Nose:  
 Mouth/Dental:  
 Breast:  
 Cardiac:

(+) Positive symptoms reported:

Chest pain, HTN, PND, DOE, Palpitations  
 Chest pain  
 HTN  
 PND  
 DOE  
 Palpitations

(-) Negative for (Patient denies symptoms of):

Chest pain, HTN, PND, DOE, Palpitations  
 Chest pain  
 HTN  
 PND  
 DOE  
 Palpitations

Respiratory:  
 GI/Digestive:  
 GU/Urologic:  
 Blood/Lymphatic:  
 Endocrine:  
 Musculoskeletal:  
 Neurologic:

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.15. VA National Primary Care Note Template: VA Primary Care New Patient - Respiratory Section**

Template: VA PC New Patient

Eyes:  
 Ears:  
 Nose:  
 Mouth/Dental:  
 Breast:  
 Cardiac:  
 Respiratory:

(+) Positive symptoms reported:

Cough, Wheeze, Dyspnea, DOE  
 Cough  
 Wheeze  
 Dyspnea  
 DOE

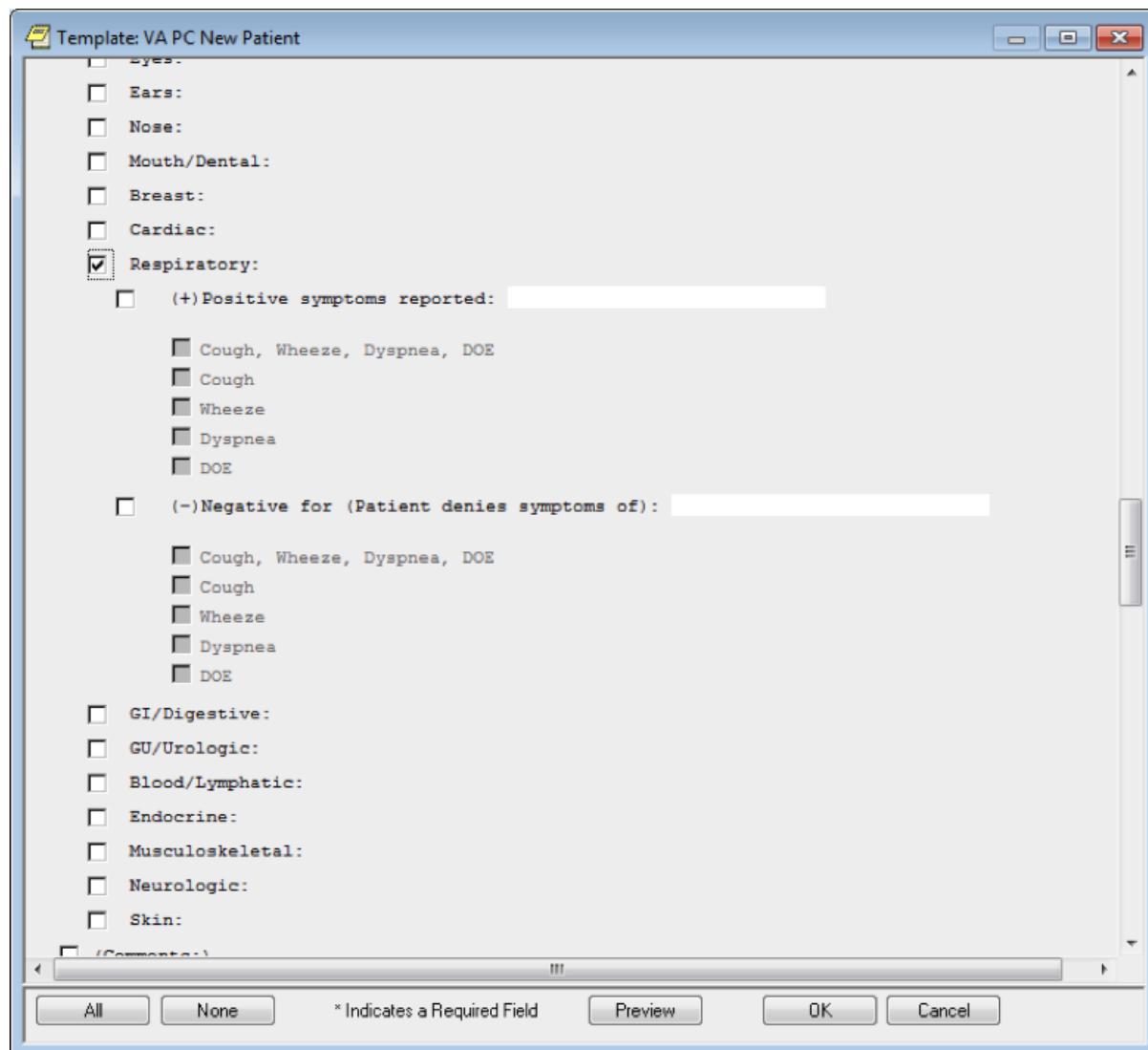
(-) Negative for (Patient denies symptoms of):

Cough, Wheeze, Dyspnea, DOE  
 Cough  
 Wheeze  
 Dyspnea  
 DOE

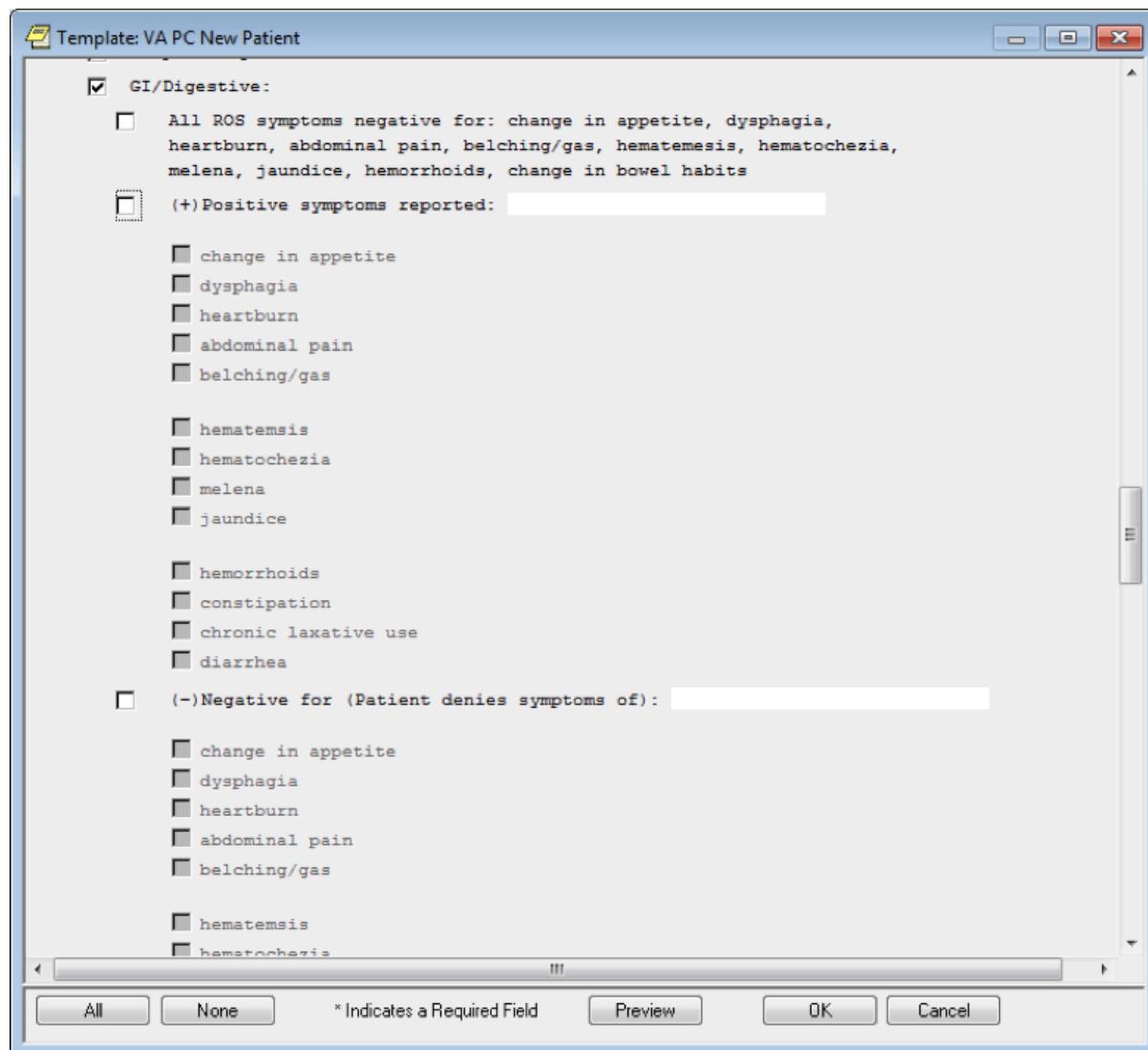
GI/Digestive:  
 GU/Urologic:  
 Blood/Lymphatic:  
 Endocrine:  
 Musculoskeletal:  
 Neurologic:  
 Skin:

(Comments...)

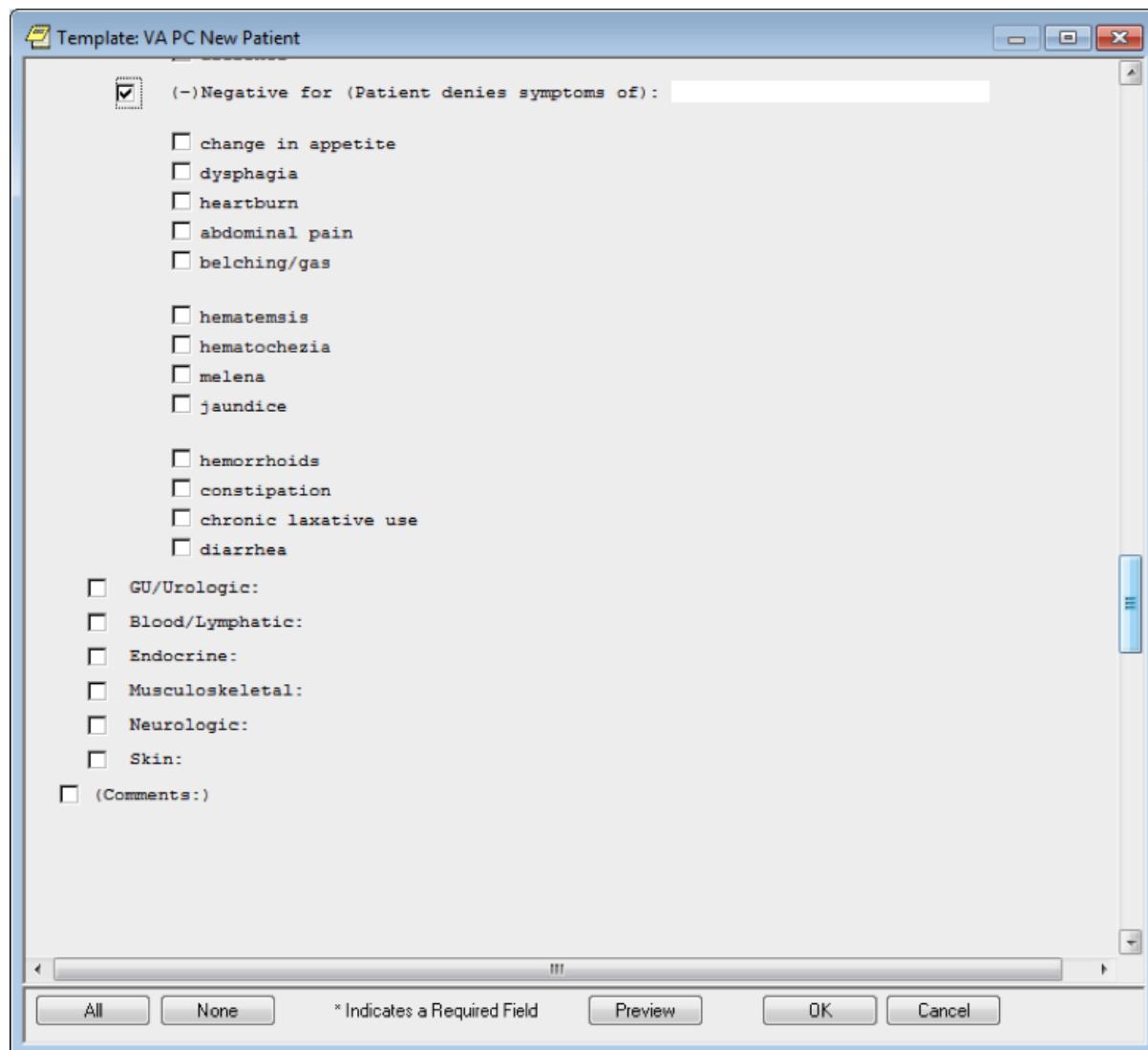
All    None    \* Indicates a Required Field    Preview    OK    Cancel



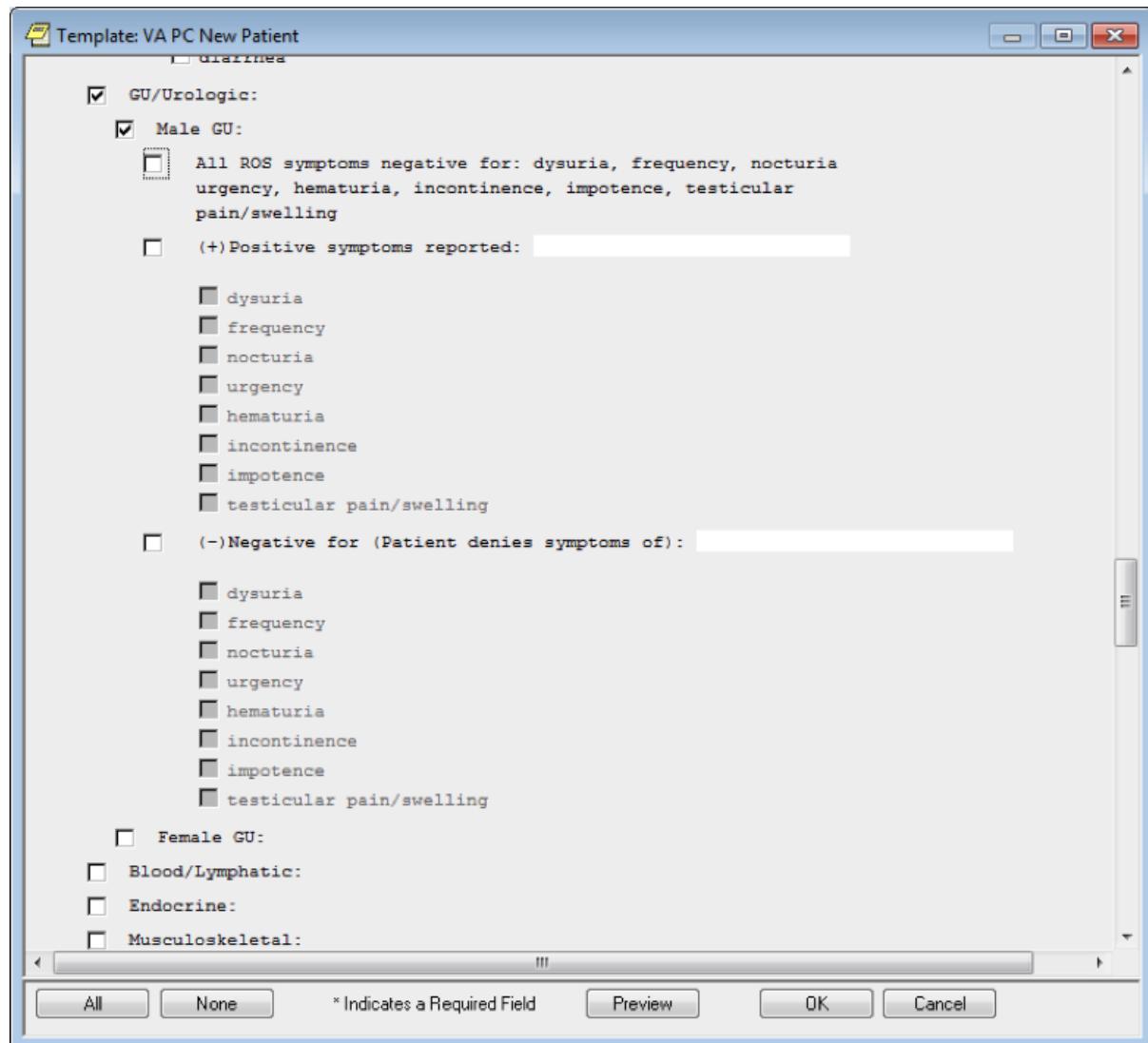
**Figure A.16. VA National Primary Care Note Template: VA Primary Care New Patient - Gastroenterology (GI)/Digestive Section**



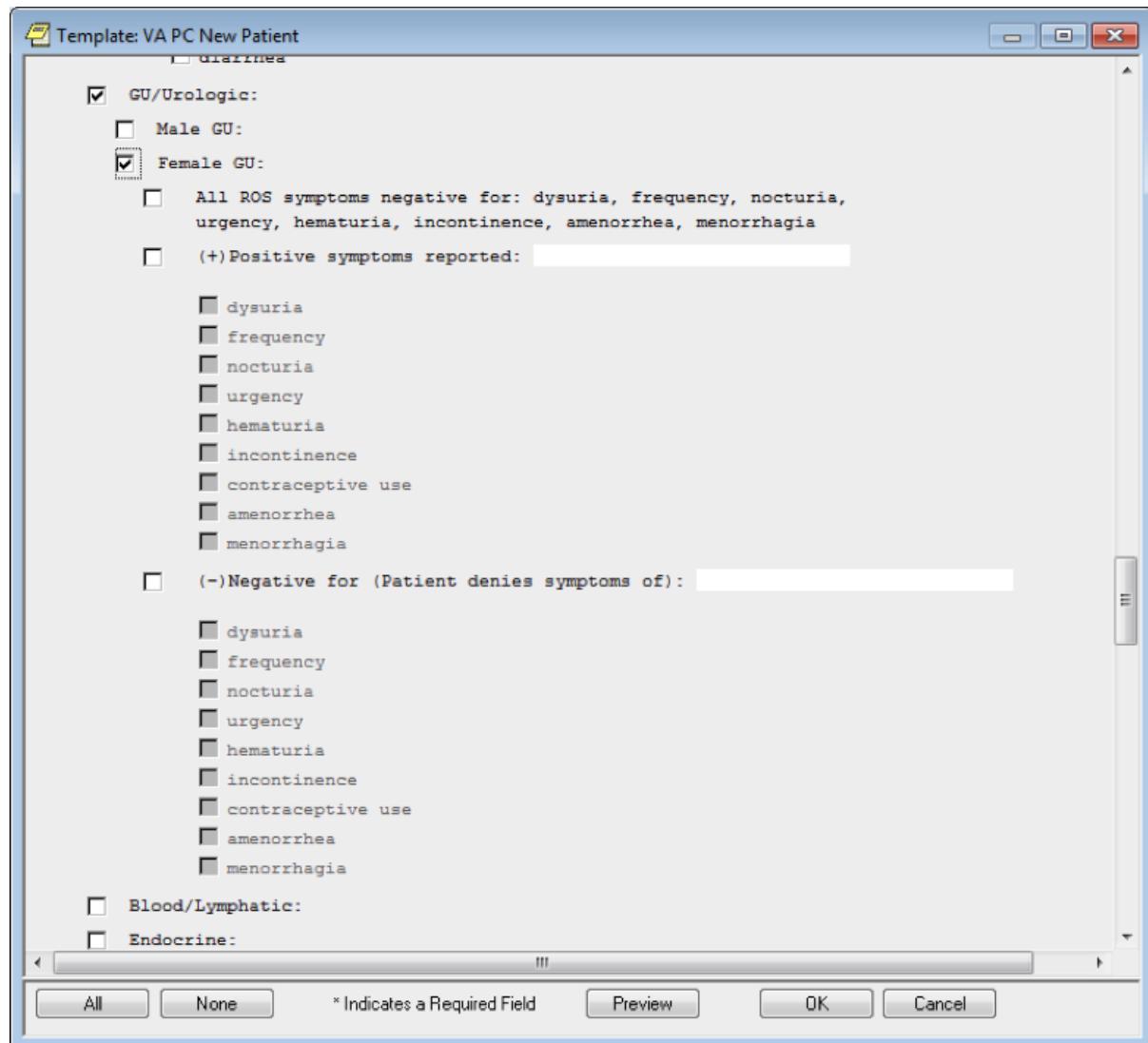
**Figure A.17. VA National Primary Care Note Template: VA Primary Care New Patient - Gastroenterology (GI)/Digestive with Negative for Symptoms Section**



**Figure A.18. VA National Primary Care Note Template: VA Primary Care New Patient - Genitourinary (GU)/Urologic and Male GU Sections**



**Figure A.19. VA National Primary Care Note Template: VA Primary Care New Patient - Genitourinary (GU)/Urologic and Female GU Sections**



**Figure A.20. VA National Primary Care Note Template: VA Primary Care New Patient - Blood/Lymphatic Section**

**Template: VA PC New Patient**

**Blood/Lymphatic:**

(+) Positive symptoms reported: \_\_\_\_\_

anemia, transfusion, easy bleeding, easy bruising, LN enlargement/pain  
 anemia  
 transfusion  
 easy bleeding  
 easy bruising  
 LN enlargement/pain

(-) Negative for (Patient denies symptoms of): \_\_\_\_\_

anemia, transfusion, easy bleeding, easy bruising, LN enlargement/pain  
 anemia  
 transfusion  
 easy bleeding  
 easy bruising  
 LN enlargement/pain

Endocrine:  
 Musculoskeletal:  
 Neurologic:  
 Skin:  
 (Comments:)

PHYSICAL EXAMINATION:  
 (----- DATA REVIEW -----) DATA REVIEW:  
(Indicate pertinent data reviewed today. Labs, Tests, X-rays, Notes, D/C, etc.)

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.21. VA National Primary Care Note Template: VA Primary Care New Patient - Endocrine Section**

**Template: VA PC New Patient**

Blood/Lymphatic:  
 Endocrine:

All ROS symptoms negative for: goiter, thyroid condition, polydipsia, polyuria and polydipsia, chronic prednisone tx  
 (+) Positive symptoms reported: \_\_\_\_\_  
  
 goiter  
 thyroid condition  
 polydipsia  
 polyuria and polydipsia  
 chronic prednisone tx  
  
 (-) Negative for (Patient denies symptoms of): \_\_\_\_\_  
  
 goiter  
 thyroid condition  
 polydipsia  
 polyuria and polydipsia  
 chronic prednisone tx

Musculoskeletal:  
 Neurologic:  
 Skin:  
 (Comments:)

PHYSICAL EXAMINATION:  
 (----- DATA REVIEW -----) DATA REVIEW:  
(Indicate pertinent data reviewed today. Labs, Tests, X-rays, Notes, D/C, etc.)  
All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.22. VA National Primary Care Note Template: VA Primary Care New Patient - Musculoskeletal Section**

**Template: VA PC New Patient**

**Musculoskeletal:**

(-) Negative for (Patient denies symptoms of):

Muscle cramps, joint pain or stiffness  
 muscle cramps  
 joint pain  
 joint stiffness  
 joint deformity  
 joint(s) involved include:

(+) Positive symptoms reported:

Muscle cramps, joint pain or stiffness  
 muscle cramps  
 joint pain  
 joint stiffness  
 joint deformity  
 joint(s) involved include:

Neurologic:

Skin:

(Comments:)

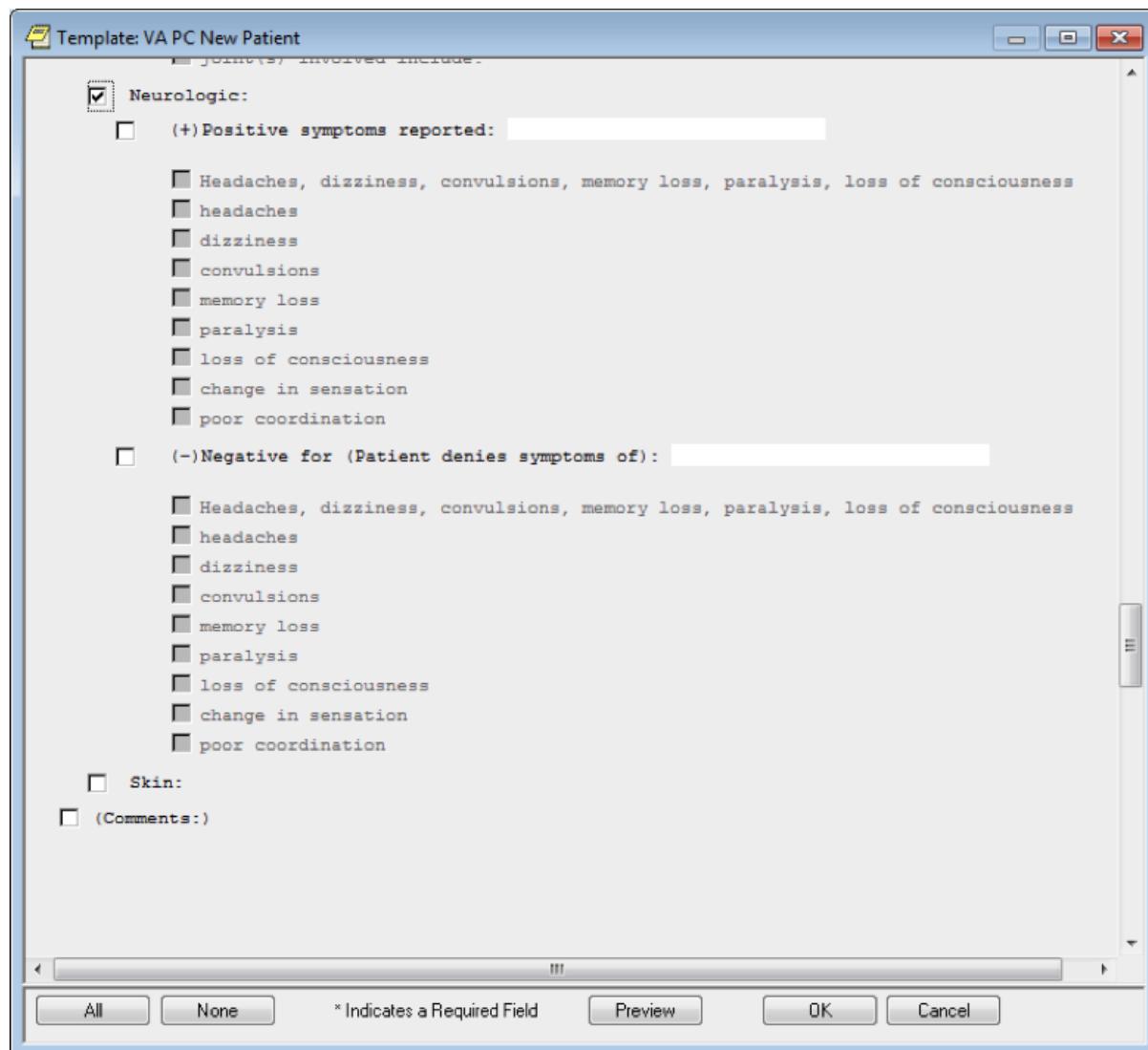
PHYSICAL EXAMINATION:

(----- DATA REVIEW -----) DATA REVIEW:  
(Indicate pertinent data reviewed today: Labs, Tests, X-rays, Notes, D/C, etc)  
(Click here for expanded point and click data review)

Lab results reviewed.

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.23. VA National Primary Care Note Template: VA Primary Care New Patient - Neurologic Section**



**Figure A.24. VA National Primary Care Note Template: VA Primary Care New Patient - Skin Section**

Template: VA PC New Patient

poor coordination

**Skin:**

(+) Positive symptoms reported: \_\_\_\_\_

Rash, lesions, acne, dry skin, itching, hives  
 rash  
 skin lesion  
 acne  
 dry skin  
 hives  
 itching

(-) Negative for (Patient denies symptoms of): \_\_\_\_\_

Rash, lesions, acne, dry skin, itching, hives  
 rash  
 skin lesion  
 acne  
 dry skin  
 hives  
 itching

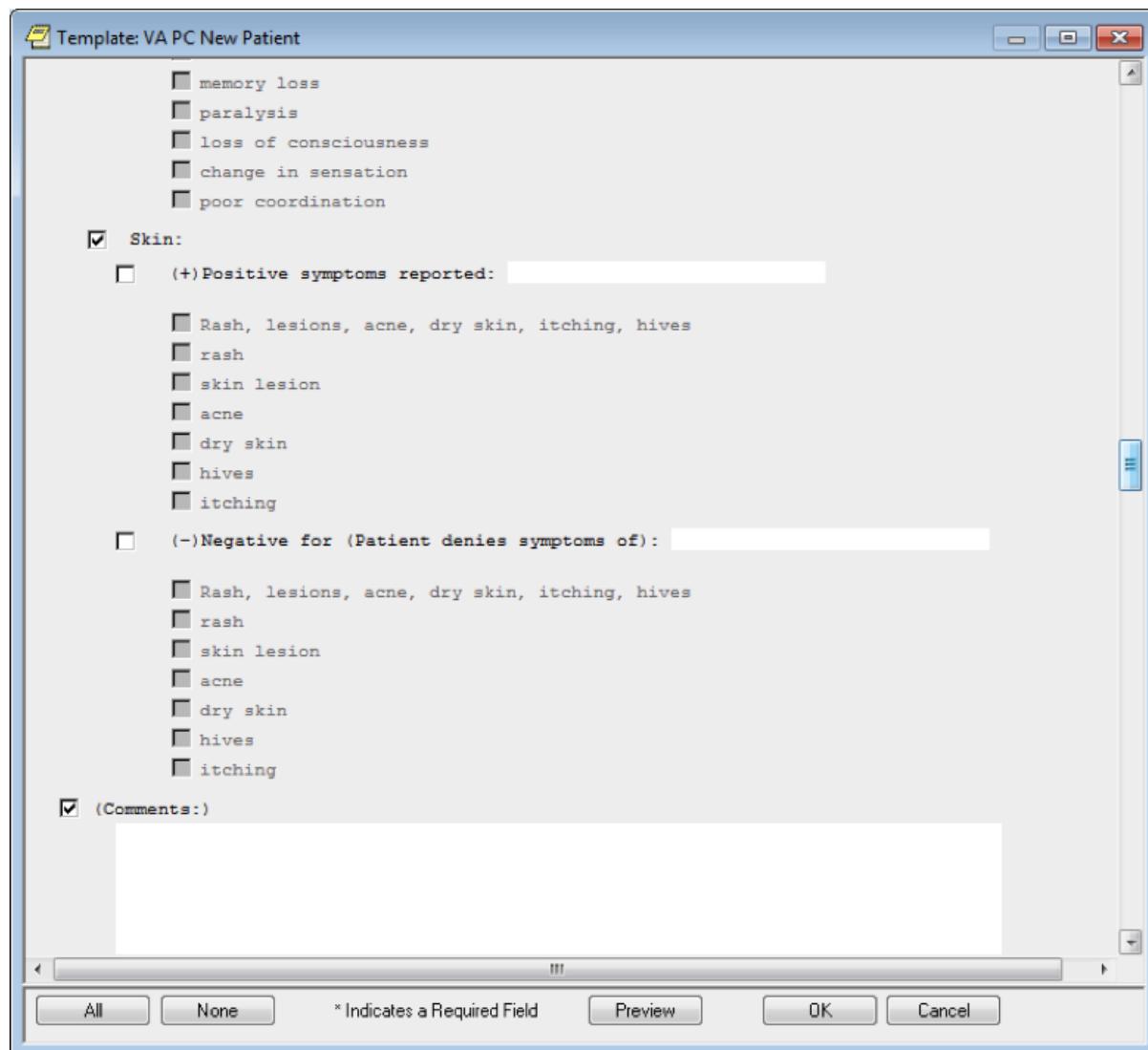
(Comments:)

PHYSICAL EXAMINATION:

(----- DATA REVIEW -----) DATA REVIEW:  
(Indicate pertinent data reviewed today: Labs, Tests, X-rays, Notes, D/C, etc)  
(Click here for expanded point and click data review)

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.25. VA National Primary Care Note Template: VA Primary Care New Patient - Skin Section with Added Comments**



**Figure A.26. VA National Primary Care Note Template: VA Primary Care New Patient - Physical Examination and Eye Exam Sections**

**Template: VA PC New Patient**

PHYSICAL EXAMINATION:

(Click to add Vitals to Note ----- CONSTITUTIONAL ----- )

VITALS (most recent, as listed in the electronic record):

B/P: 128/95 (07/17/2017 09:31)  
Pulse: 89 (07/17/2017 09:31)  
Temperature: 98 F [36.7 C] (07/17/2017 09:31)  
Weight: 220 lb [100.0 kg] (05/08/2017 08:43)  
Height: 65 in [165.1 cm] (05/08/2017 08:43)  
BMI:  
Pain: 0 (07/17/2017 09:31) (0-10 scale)

APPEARANCE:  WD  WN  NAD  Overweight  Thin  Emaciated

(-----HEAD-----)  
HEAD: (Document pertinent normal & abnormalities in word processing field)  
 Not examined.  No sign of trauma.  Evidence of trauma.

(----- EYES -----)

EYE EXAM - (Document pertinent normal & abnormalities in word processing field)

PUPILS:  PERRLA.  Anisocoria.  Pupil abnormality.

RIGHT EYE:  Not examined

LEFT EYE:  Not examined

|  
(OTHER PERTINENT FINDINGS:)

(-----ENT-----)  
EAR EXAM - (Document pertinent normal & abnormalities in word processing field)

All None \* Indicates a Required Field Preview OK Cancel

**Figure A.27. VA National Primary Care Note Template: VA Primary Care New Patient - Ear, Nose, and Throat (ENT), Neck, and Chest Sections**

**Template: VA PC New Patient**

(-----ENT-----)

EAR EXAM - (Document pertinent normal & abnormalities in word processing field)  
 RIGHT:  N/A.  Normal TM.  Abnormal TM.  Impacted cerumen.

LEFT:  N/A.  Normal TM.  Abnormal TM.  Impacted cerumen.

NOSE:  Not examined  Normal  Abnormal

OROPHARYNX:  N/A  No erythema.  Mild erythema.  Diffuse erythema.

(Comments:)

(----- NECK -----)

(Document pertinent normal & abnormalities in word processing field) THYROID:  
 Not examined.  No thyromegaly.  (+) Thyroid enlarged.

NECK:  Not examined.  Supple.  Muscle spasm.  Nuchal rigidity.

CERVICAL ADENOPATHY:  Not examined  Absent.  Present.

(----- CHEST -----)

(Document pertinent normal & abnormalities in word processing field) THORAX/CHEST:  
 Not examined  Normal  Abnormal

LUNG AUSCULTATION:  Clear  Wheeze  Rhonchi

LUNG PERCUSSION:  Clear  Hyperresonant  Dull

(----- CHEST/FEMALE -----)

(Document pertinent normal & abnormalities in word processing field)

BREAST EXAM:  Not examined  Normal  Abnormal

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.28. VA National Primary Care Note Template: VA Primary Care New Patient - Chest/Female and Cardiovascular Sections**

**Template: VA PC New Patient**

(----- CHEST/FEMALE -----)  
 (Document pertinent normal & abnormalities in word processing field)

BREAST EXAM:  Not examined  Normal  Abnormal

(----- CARDIOVASCULAR -----)

CARDIOVASCULAR -

NECK VEINS:  Not examined.  No JVD.  (+) JVD: \_\_\_\_\_

HEART-PMI:  5th ICS MCL  Laterally displaced  Not found

INSPECTION:  Not examined  Normal  Abnormal

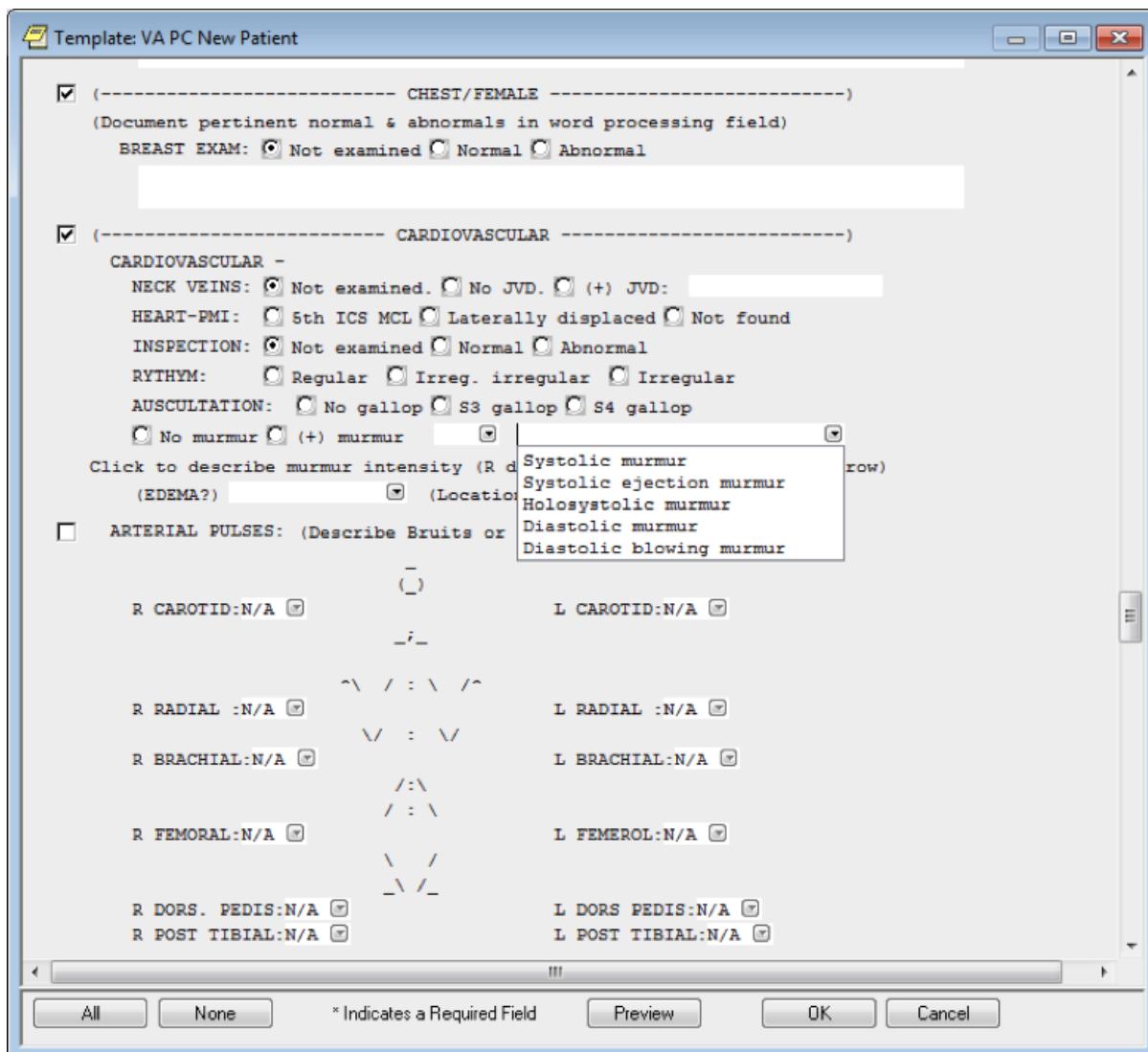
RYTHYM:  Regular  Irreg. irregular  Irregular

AUSCULTATION:  No gallop  S3 gallop  S4 gallop  
 No murmur  (+) murmur  ( )  
 Click to describe murmur intensity (EDEMA?)  1/6  2/6  3/6  4/6  5/6  6/6 down arrow) & timing (L down arrow)  
 (EDEMA?)  1/6  2/6  3/6  4/6  5/6  6/6 down arrow) & timing (L down arrow)

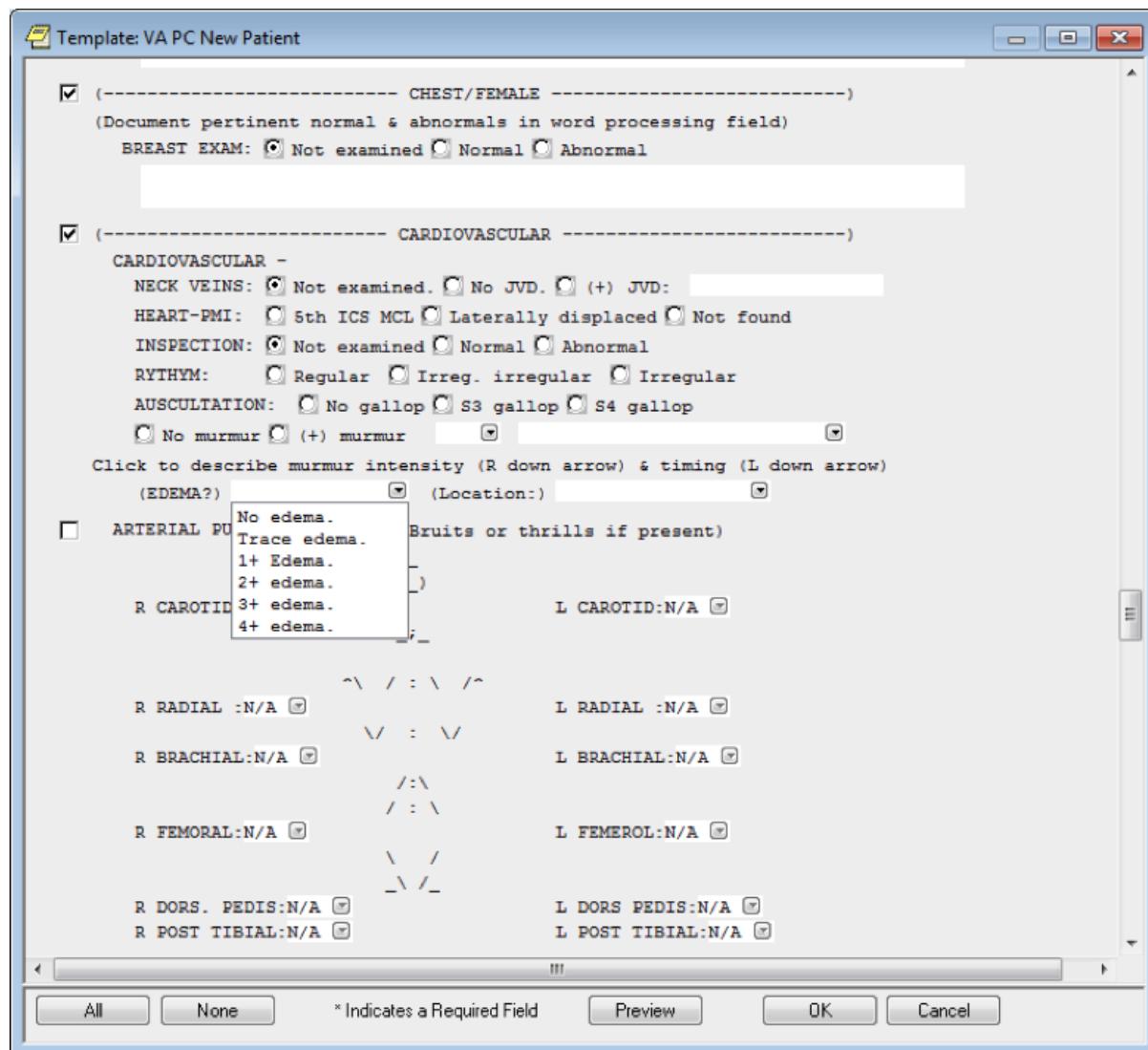
ARTERIAL PULSES: (Describe Brachial pulses)  
 R CAROTID:N/A  L CAROTID:N/A   
 R RADIAL :N/A  L RADIAL :N/A   
 R BRACHIAL:N/A  L BRACHIAL:N/A   
 R FEMORAL:N/A  L FEMEROL:N/A   
 R DORS. PEDIS:N/A  L DORS PEDIS:N/A   
 R POST TIBIAL:N/A  L POST TIBIAL:N/A

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.29. VA National Primary Care Note Template: VA Primary Care New Patient - Chest/Female and Cardiovascular Sections - Specifying Auscultation Murmur Drop-down**



**Figure A.30. VA National Primary Care Note Template: VA Primary Care New Patient - Chest/Female and Cardiovascular Sections - Specifying Edema Drop-down**



**Figure A.31. VA National Primary Care Note Template: VA Primary Care New Patient - Chest/Female and Cardiovascular Sections, Specifying Edema Location**

**Template: VA PC New Patient**

(----- CHEST/FEMALE -----)  
 (Document pertinent normal & abnormalities in word processing field)

BREAST EXAM:  Not examined  Normal  Abnormal

(----- CARDIOVASCULAR -----)

CARDIOVASCULAR -

NECK VEINS:  Not examined.  No JVD.  (+) JVD: \_\_\_\_\_

HEART-PMI:  5th ICS MCL  Laterally displaced  Not found

INSPECTION:  Not examined  Normal  Abnormal

RYTHYM:  Regular  Irreg. irregular  Irregular

AUSCULTATION:  No gallop  S3 gallop  S4 gallop  
 No murmur  (+) murmur \_\_\_\_\_

Click to describe murmur intensity (R down arrow) & timing (L down arrow)

(EDEMA?)  (Location:

ARTERIAL PULSES: (Describe Bruits or thr:

R CAROTID:N/A <input type="checkbox"/>	<input type="button" value="Down Arrow"/>
R RADIAL :N/A <input type="checkbox"/>	<input type="button" value="Down Arrow"/>
R BRACHIAL:N/A <input type="checkbox"/>	<input type="button" value="Down Arrow"/>
R FEMORAL:N/A <input type="checkbox"/>	<input type="button" value="Down Arrow"/>
R DORS. PEDIS:N/A <input type="checkbox"/>	<input type="button" value="Down Arrow"/>
R POST TIBIAL:N/A <input type="checkbox"/>	<input type="button" value="Down Arrow"/>

L RADIAL :N/A <input type="checkbox"/>	<input type="button" value="Down Arrow"/>
L BRACHIAL:N/A <input type="checkbox"/>	<input type="button" value="Down Arrow"/>
L FEMEROL:N/A <input type="checkbox"/>	<input type="button" value="Down Arrow"/>
L DORS PEDIS:N/A <input type="checkbox"/>	<input type="button" value="Down Arrow"/>
L POST TIBIAL:N/A <input type="checkbox"/>	<input type="button" value="Down Arrow"/>

Both feet  
 Both ankles  
 Both lower legs  
 Right foot  
 Right ankle  
 Right lower leg  
 Left foot  
 Left ankle  
 Left lower leg

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.32. VA National Primary Care Note Template: VA Primary Care New Patient - Arterial Pulses, R Carotid Section**

**Template: VA PC New Patient**

ARTERIAL PULSES: (Describe Bruits or thrills if present)

R CAROTID: N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/> <input type="button" value="3+"/> <input type="button" value="4+"/> R RADIAL : <input type="button" value="N/A"/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/> <input type="button" value="3+"/> <input type="button" value="4+"/> R BRACHIAL:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/>  R FEMORAL:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/>  R DORS. PEDIS:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/>  R POST TIBIAL:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/>	L CAROTID:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/>  L RADIAL :N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/>  L BRACHIAL:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/>  L FEMEROL:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/>  L DORS PEDIS:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/>  L POST TIBIAL:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/>
---	--

(----- ABDOMEN/GI -----)

ABDOMEN: (Document pertinent normal & abnormalities, scars or hernias in word processing field)

Appearance:  Flat.  Distended.  Ascites.

Palpation:  Soft  Non-tender  Tender  Tympanitic  Firm

No organomegaly  No masses  Hepatomegaly  Splenomegaly

Bowel sounds:  Normal.  Decreased.  Hyperactive.  Absent.

RECTAL:  Not Examined.  Normal.  Pertinent finding (see below):

(----- GU/MALE -----)

MALE GU EXAM: (Document pertinent normal & abnormalities in word processing field)

\* Indicates a Required Field

**Figure A.33. VA National Primary Care Note Template: VA Primary Care New Patient - Extremities, Musculoskeletal, and Deep Tendon Reflexes Sections**

**Template: VA PC New Patient**

(----- EXTREMITIES -----)

EXTREMITIES (Document pertinent normal & abnormalities in word processing field)

UPPER:  Not Examined.  Normal.  Pertinent finding (see below):

LOWER:  Not Examined.  Normal.  Pertinent finding (see below):

(----- MUSCULOSKELETAL -----)

LUMBAR BACK EXAM: (Document pertinent normal & abnormalities in word processing field)

PALPATION:  No tenderness  Tenderness.  (+) Muscle spasm.

STRAIGHT LEG LIFT:  Negative.  Positive.  Not performed.

(-----DEEP TENDON REFLEXES-----) DEEP TENDON

REFLEXES

RT BICEPS:	N/A	LT BICEPS:	N/A
N/A		LT TRICEPS:	N/A
RT TRICEPS	0	LT TRICEPS	N/A
1+		LT PATELLA:	N/A
2+		LT ACHILLES:	N/A
3+			
4+			

RT PATELLA:

RT ACHILLES:  LT ACHILLES:

(----- NEUROLOGIC -----) NEUROLOGIC EXAM

CRANIAL NERVES:  Not examined  Normal  Abnormal

MOTOR EXAM:  Not examined  Normal  Abnormal

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.34. VA National Primary Care Note Template: VA Primary Care New Patient - Abdomen/Gastroenterology (GI), Genitourinary (GU)/Male, and GU/Female Sections**

**Template: VA PC New Patient**

(----- ABDOMEN/GI -----)

ABDOMEN: (Document pertinent normal & abnormalities, scars or hernias in word processing field)

Appearance:  Flat.  Distended.  Ascites.

Palpation:  Soft  Non-tender  Tender  Tympanitic  Firm

No organomegaly  No masses  Hepatomegaly  Splenomegaly

Bowel sounds:  Normal.  Decreased.  Hyperactive.  Absent.

RECTAL:  Not Examined.  Normal.  Pertinent finding (see below):

(----- GU/MALE -----)

MALE GU EXAM: (Document pertinent normal & abnormalities in word processing field)

PROSTATE:  Not examined  Normal  Abnormal

SCROTUM:  Not examined  Normal  Abnormal

PENIS:  Not examined  Normal  Abnormal

(----- GU/FEMALE -----)

PELVIC EXAM: (Document pertinent normal & abnormalities in word processing field)

PERINIUM:  Not examined  Normal  Abnormal

VAGINA:  Not examined  Normal  Abnormal

CERVIX:  Not examined  Normal  Abnormal

BIMANUAL:  Not examined  Normal  Abnormal

RECTAL:  Not examined  Normal  Abnormal

(----- EXTREMITIES -----)

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.35. VA National Primary Care Note Template: VA Primary Care New Patient - Neurologic, Lymphatics, Dermatology, and Psychiatric Sections**

**Template: VA PC New Patient**

(----- NEUROLOGIC -----) NEUROLOGIC EXAM

CRANIAL NERVES:  Not examined  Normal  Abnormal  
 MOTOR EXAM:  Not examined  Normal  Abnormal  
 SENSORY:  Not examined  Normal  Abnormal

(----- LYMPHATICS -----)  
 (Include location, laterality, size & consistency if palpable) LYMPHATICS:  Normal.  
 Pertinent finding (see below):

(----- DERMATOLOGY -----)  
 (Include turgor, bruising, rash, hair, nails. Lesions: location & size) SKIN:  Normal.  
 Pertinent finding (see below):

(----- PSYCHIATRIC -----) PSYCHIATRIC:  
 (Include assessment of 1) Judgment/insight, 2) Orientation to time, place, person, 3)recent and remote memory, 4) Mood/affect.)  
 JUDGMENT:  Good  Fair  Poor  Not examined  
 INSIGHT:  Good  Fair  Poor  Not examined  
 ORIENTATION:   
 MOOD:  Alert  Depressed  Not evaluated

RECENT MEMORY:  Good  Fair  Poor  Not examined  
 REMOTE MEMORY:  Good  Fair  Poor  Not examined

MMSE SCORE: \_\_\_\_\_ (Mini-Mental Status Examination)

(----- DATA REVIEW -----) DATA REVIEW:

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.36. VA National Primary Care Note Template: VA Primary Care New Patient - Psychiatric, Data including Lab Results Reviewed**

**Template: VA PC New Patient**

(----- PSYCHIATRIC -----) PSYCHIATRIC:

(Include assessment of 1) Judgment/insight, 2) Orientation to time, place, person, 3)recent and remote memory, 4) Mood/affect.)

JUDGMENT:  Good  Fair  Poor  Not examined

INSIGHT:  Good  Fair  Poor  Not examined

ORIENTATION:

MOOD:  Alert  Depressed  Not evaluated

RECENT MEMORY:  Good  Fair  Poor  Not examined

REMOTE MEMORY:  Good  Fair  Poor  Not examined

MMSE SCORE: \_\_\_\_\_ (Mini-Mental Status Examination)

(----- DATA REVIEW -----) DATA REVIEW:

(Indicate pertinent data reviewed today: Labs, Tests, X-rays, Notes, D/C, etc)

(Click here for expanded point and click data review)

Lab results reviewed.

Date of lab: Jan

Results:

Unremarkable  
 Abnormal  
 Remarkable for

Follow-up Action:

None at this time  
 Recheck lab at future visit  
 Continue current treatment  
 Adjust medication

HbA1C results reviewed.  
 LDL-cholesterol result reviewed.  
 Chest X-ray results reviewed.

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.37. VA National Primary Care Note Template: VA Primary Care New Patient - HbA1c and Low-density lipoprotein (LDL)-cholesterol Results Reviewed**

Template: VA PC New Patient

HbA1C results reviewed.

Date of HbA1C:

Result:

Acceptable  
 Above target  
 Within target range

Follow-up Action:

None at this time  
 Continue current treatment  
 Adjust diabetic medications  
 Refer to Dietitian  
 Refer to Diabetes Clinic  
 Other:

LDL-cholesterol result reviewed.

Date of LDL-cholesterol:

Result:

Acceptable  
 Above target  
 Within target range

Follow-up Action:

None at this time  
 Continue current treatment  
 Adjust diabetic medications  
 Refer to Dietitian  
 Refer to Diabetes Clinic  
 Other:

Chest X-ray results reviewed.

X-Ray results reviewed.

EKG reviewed.

Progress Note was reviewed - date of note:

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.38. VA National Primary Care Note Template: VA Primary Care New Patient - X-ray Results Reviewed**

Template: VA PC New Patient

Chest X-ray results reviewed.

Date of Chest X-ray:

Results:

Unremarkable  
 Abnormal  
 Remarkable for

Follow-up Action:

None at this time  
 Recheck X-ray at future visit  
 Continue current treatment  
 CT ordered  
 Other:

X-Ray results reviewed.

Date of X-ray:

Results:

Unremarkable  
 Abnormal  
 Remarkable for

Follow-up Action:

None at this time  
 Recheck X-ray at future visit  
 Continue current treatment  
 CT ordered  
 Other:

EKG reviewed.

Progress Note was reviewed - date of note:       
(To use the calendar style date box click here -->)

Discharge Summary reviewed - date of summary:      
(To use the calendar style date box click here -->)

All    None    \* Indicates a Required Field    Preview    OK    Cancel

**Figure A.39. VA National Primary Care Note Template: VA Primary Care New Patient – Electrocardiogram (EKG) Reviewed**

**Template: VA PC New Patient**

EKG reviewed.

Date of electrocardiogram:

Result:

Unremarkable  
 Abnormal  
 Remarkable for

Follow-up Action:

None at this time  
 Recheck EKG at future visit  
 Continue current treatment  
 Medication adjusted  
 Cardiology referral  
 Other:

Progress Note was reviewed - date of note:       
(To use the calendar style date box click here -->)

Discharge Summary reviewed - date of summary:       
(To use the calendar style date box click here -->)

Outside records were reviewed. (Comments:)

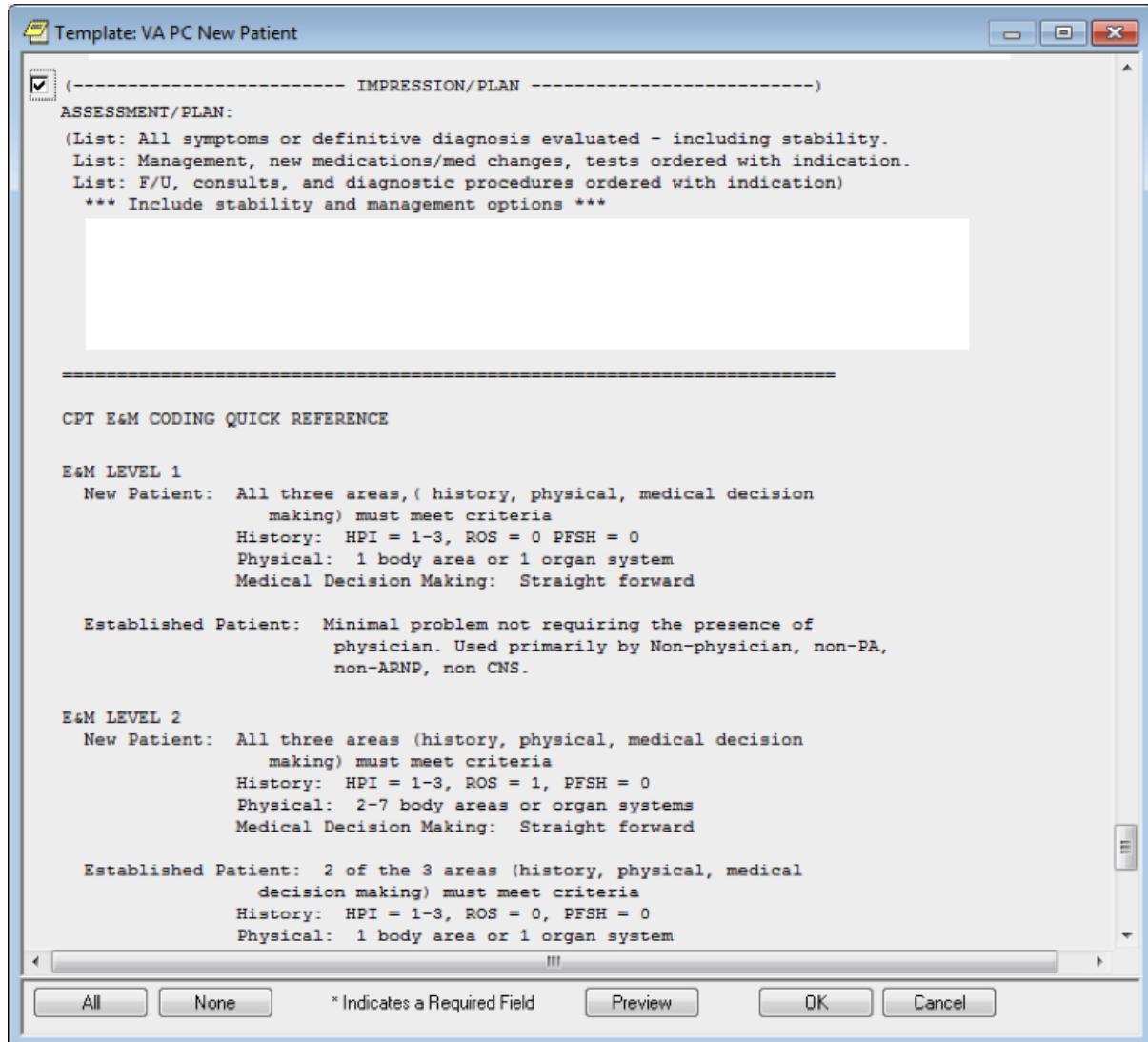
(Comments:)

(----- IMPRESSION/PLAN -----)

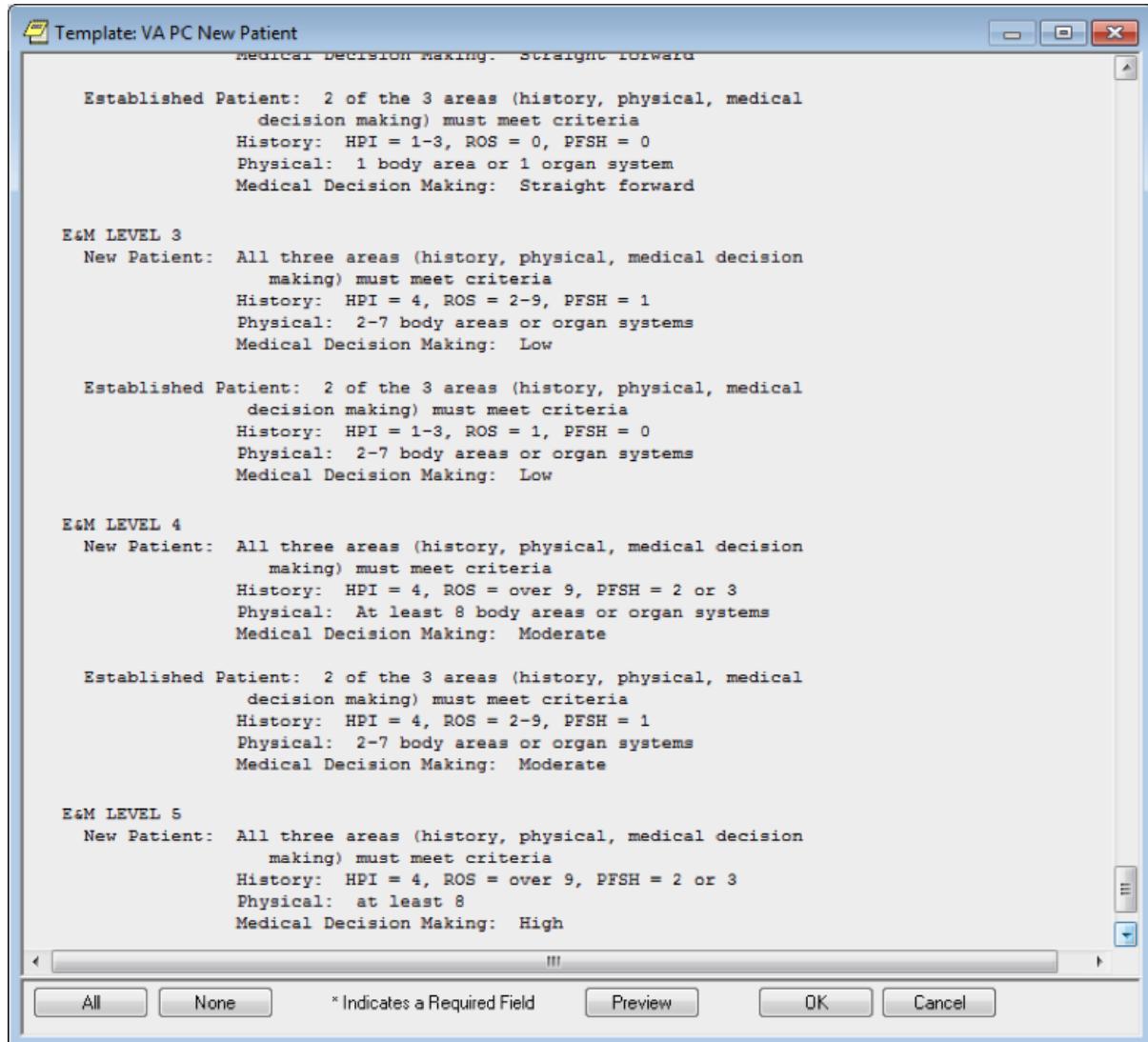
ASSESSMENT/PLAN:  
(List: All symptoms or definitive diagnosis evaluated - including stability.  
List: Management, new medications/med changes, tests ordered with indication.  
List: F/U, consults, and diagnostic procedures ordered with indication)  
\*\*\* Include stability and management options \*\*\*

All    None    \* Indicates a Required Field    Preview    OK    Cancel

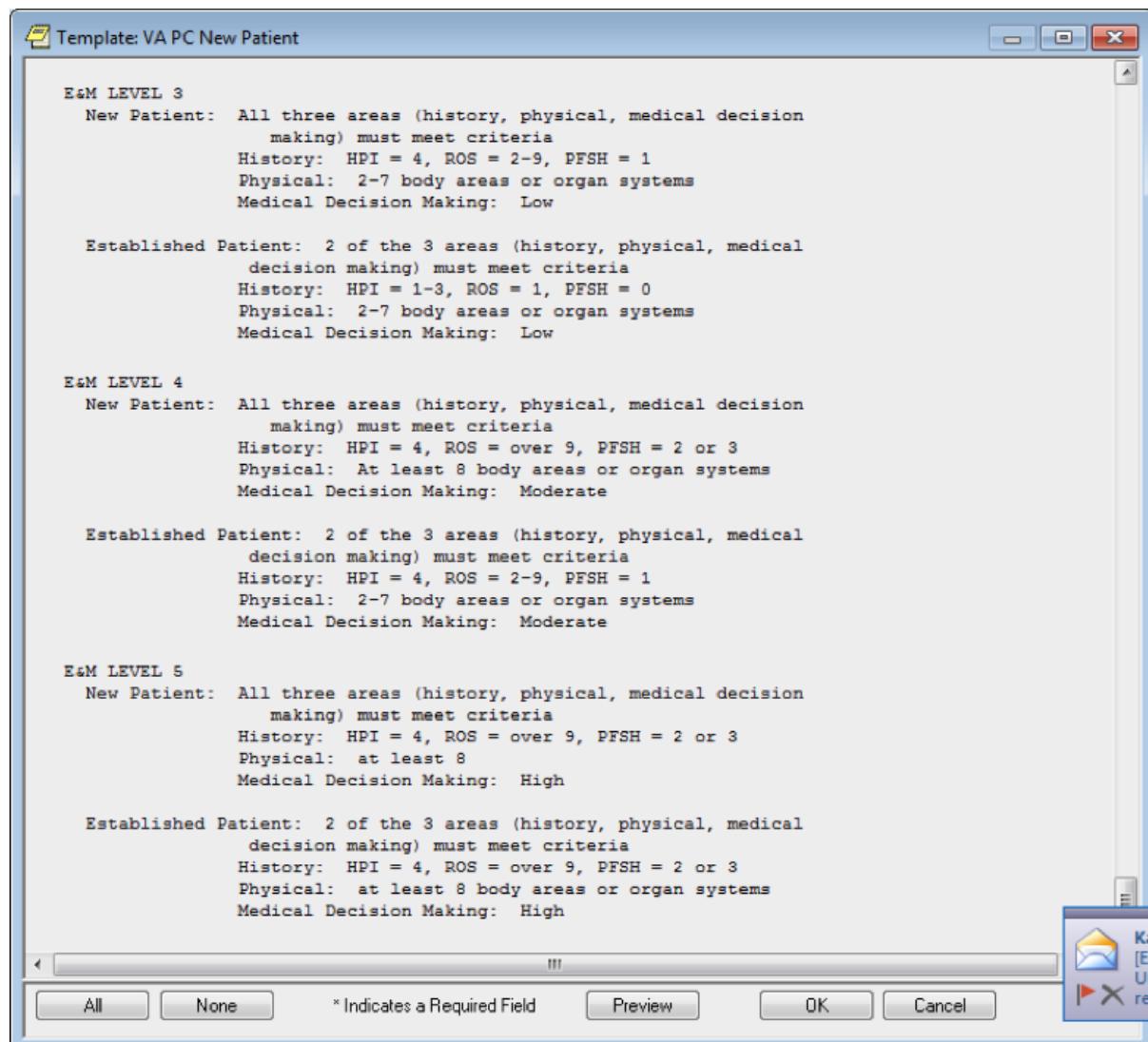
**Figure A.40. VA National Primary Care Note Template: VA Primary Care New Patient - Impression/Plan**



**Figure A.41. VA National Primary Care Note Template: VA Primary Care New Patient - Evaluation and Management (E & M) Levels 3-5**



**Figure A.42. VA National Primary Care Note Template: VA Primary Care New Patient – Evaluation and Management (E & M) Level 5: Established Patients**



**Figure A.43. VA National Primary Care Note Template: VA Primary Care Clinical Reminder Resolution Assessing Care of Vulnerable Elders (ACOVE) Functional Status**

**KATZ ADL TOOL**

**Katz ADL Score Notes:**  
 ADL independence = 1 point  
 ADL dependence = 0 point

**Bathing:** \*

1 POINT - Bathes self completely or needs help in bathing only a single part of the body such as back, genital area.  
 0 POINT - Needs help bathing more than one body part of the body getting out of tub or shower. Requires total bathing.

**Dressing:** \*

1 point - Gets clothes from closets, etc, puts them on complete with fasteners. May have help tying shoes.  
 0 point - Needs help with dressing self or needs to be completely dressed.

**Toileting:** \*

1 POINT - Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.  
 0 POINT - Needs help transferring to the toilet, cleaning self or uses bedpan or commode.

**Transferring:** \*

1 POINT - Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.  
 0 POINT - Needs help in moving from bed to chair or requires a complete transfer.

**Continence:** \*

1 POINT - Exercises complete self control over urination and defecation.  
 0 POINT - Is partially or totally incontinent of bowel or bladder.

**Feeding:** \*

1 POINT - Gets food from plate into mouth without help. Preparation of food may be done by another person.  
 0 POINT - Needs partial or total help with feeding or requires parental feeding.

Katz ADL Index Total Points = \*  
 6 = High (patient independent)  
 0 = Low (patient very dependent)

**INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) SCALE (Lawton)**

Begin assessment

Ability to use telephone:

1 point - Operates telephone on own initiative; looks up and dials numbers, etc.  
 1 point - Dials a few well-known numbers  
 1 point - Answers telephone but does not dial  
 0 points - Does not use telephone at all

**ACOVE Functional Status :**  
**KATZ ADL TOOL**  
 Katz ADL Score Notes:  
 ADL independence = 1 point  
 ADL dependence = 0 point

Health Factors: IADL ASSESSMENT COMPLETED, KATZ ADL INDEX DONE

\* Indicates a Required Field

---

## **Appendix B. Basic Laboratory Panel Definition**

Blood Urea Nitrogen

Calcium

Chloride

CO<sub>2</sub> (Carbon Dioxide, Bicarbonate)

Creatinine

Glucose

Potassium

Sodium

---

# Acronyms

Acronyms	Description
ACOVE	Assessing Care of Vulnerable Elders
BMI	Body Mass Index
BP	Blood Pressure
BPM	Beats Per Minute
CCWP	Clinical Content White Paper
CDS	Clinical Decision Support
CO2	Carbon Dioxide
DoD	Department of Defense
E&M	Evaluation and Management
EKG	Electrocardiogram
ENT	Ears, Nose, Throat
GI	Gastroenterology
GU	Genitourinary
HEENT	Head, Eyes, Ears, Nose, Throat
HL7	Health Level 7
KBS	Knowledge Based Systems
KNART	Knowledge Artifact
LDL	Low-density Lipoprotein
OIIG	Office of Informatics and Information Governance
OTC	Over the Counter
PTSD	Post-Traumatic Stress Disorder
SME	Subject Matter Expert
TO	Task Order
USPSTF	United States Preventive Services Task Force
VA	Department of Veterans Affairs
VACO	VA Central Office
VAMC	VA Medical Center