Calm & approp; thought, content, process & perception appear intact

Skin: color WNL, no rash/lesions, brisk cap refill, turgor WNL

Head: Normal Cephalic

Eyes: eyelids WNL, conjunctiva pink, sclera clear, PERRLA

Fundi: sharp disc margins, no hemorrhages or exudates

Ears: canals clear, TM’s intact, normal light reflex

Nose: no discharge, no congestion, no sinus tenderness

Oral: buccal mucosa pink, pharynx w/o erythema/ exudate, dentition WNL

Neck: supple, no adenopathy, no thyromegaly

CV: RRR, no M/G/R

Lymph: soft, not enlarged, non-tender

Lungs: clear breath sounds, good air movement, non-labor

Breast: no masses, no nipple D/C, no axillary adenopathy, no skin changes

Back: no deformities, negative SLR, no CVAT

Extrem: no edema, no tenderness

Rectal: adeq sphincter tone, no masses/lesions or hemorrhoids

GU: no penile/ testic lesions, no D/C, NT, no masses

GU: ext gen WNL, vagina WNL, uterus/cervix WNL, no CMT, adenexa WNL

M/S: no joint tenderness, no swelling, ROM WNL

Neuro: DTR's 2+ and equal bilat, sensation WNL, strength WNL, coordination WNL, gait WNL

Signature: ___________________________
### Labs

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<th>Assessment</th>
<th>Plan</th>
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### Referrals

### Education

Return to Clinic: ______________________________

Signature: ____________________________ Date: ____________________________

### Follow-Up Notes

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DHHS 4059 (03/05)
PHNPD (Review 07/07)
PATIENT VISIT RECORD  (DHHS 4059)

This form can to be used for preventive or problem visits.

PATIENT LABEL

Attach in this space the computer generated identification label or emboss in this space the information imprinted on the patient's plastic identification card. When a plastic card or label is not available, manually record the patient's name (last name, first name and middle initial), identification number, date of birth (MM-DD-YYYY), race, ethnicity, gender, and county of residence.

VITAL SIGNS GRID

Document vital signs, etc., as indicated in this grid.

CHIEF COMPLAINT

Document chief complaint in the space following cc:

SUBJECTIVE DATA

Document history and other subjective information obtained from the patient in the space provided. The person taking the history should sign in the space provided using the legal signature and credentials.

REVIEW OF SYSTEMS

Check (✓) the box by the system if the system is within normal limits. Be sure to document pertinent negatives for the affected or related systems. Leave box blank and describe any exceptions or abnormalities on line provided.

EXAMINATION

Document results of the physical examination in the space provided. Check (✓) the box by the system if the system statement is accurate for the exam of that system. If the statement is partially accurate, check (✓) the box and describe the exceptions, abnormalities on the line provided. If the statement is inaccurate, leave the box blank and describe on the line provided. If system is not examined, leave the box and line blank. The person performing the examination should sign in the space provided using the legal signature and credentials.

LABS

Document any labs done prior to or during the visit and their results in the space provided. Also document labs ordered.

ASSESSMENT

Document the assessment or diagnosis in the space provided.

PLAN

Document the plan in the space provided.

REFERRALS

Document as appropriate.

EDUCATION

Document patient education in the space provided.

SIGNATURE

The provider of the exam, assessment and plan should sign again on this side of the form using the legal signature and credentials.

FOLLOW-UP/NOTES

Document date of any additional notes or follow-up information pertinent to this visit in the space provided followed by the legal signature and credentials of the person documenting this information.