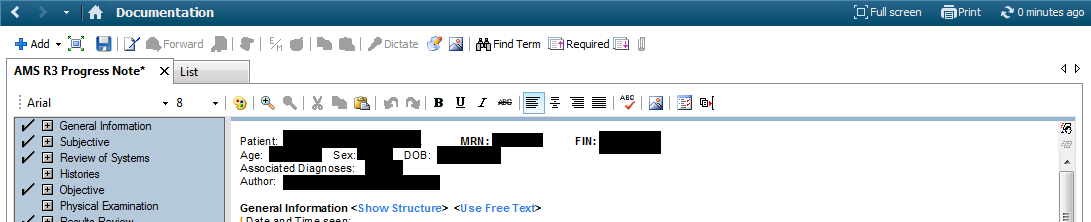
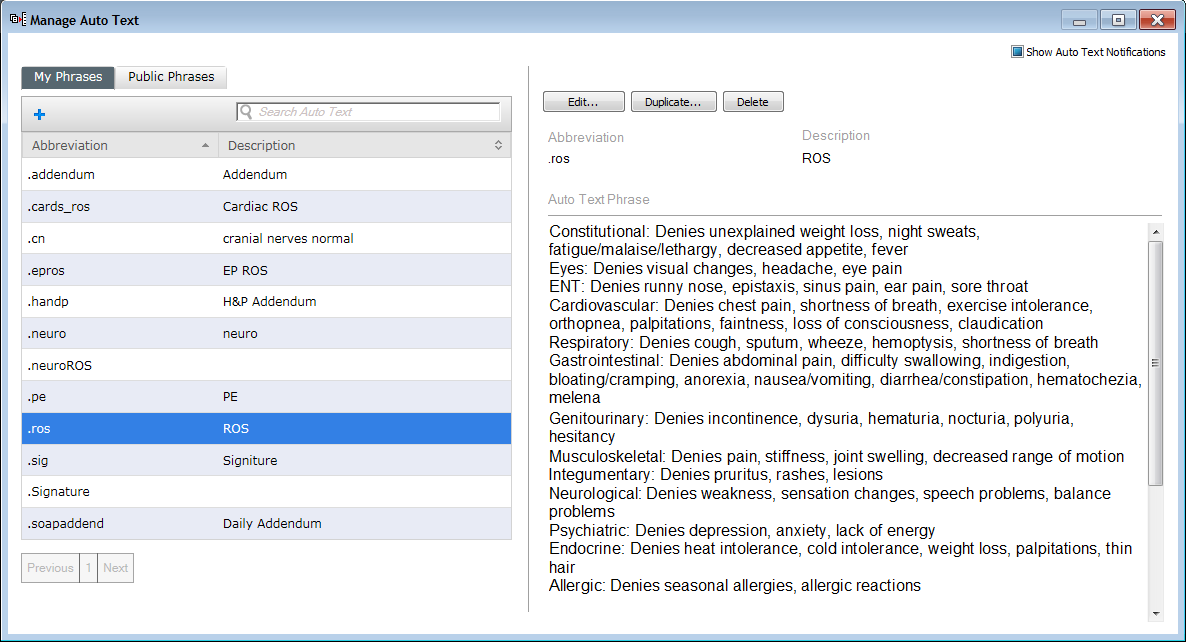
**Dot Phrases**

These are generic templates that will help you be more efficient in your charting and some will even remind you extra questions to ask. Remember, these are a guide, you will need to edit these as needed. If you want to use a specific “dot phrase,” you will copy and paste into your Cerner under whatever shortcut you identify. The button to do this is available when you are editing any note and the cursor is in a text field.





**MALE REVIEW OF SYSTEMS**

General: No fatigue, no fever, no night sweats, no unintentional weight loss or gain

GI: No abdominal pain, no constipation, no diarrhea, no vomiting

Skin: No itching, no rash

Ears nose throat: No ear drainage, no hearing loss, no nasal drainage, no sore throat, no dry mouth, no mouth lesions

Eyes: No eye discharge, no blurred vision, no eye pain, no vision changes

Urinary: No pain with urination, no bloody urine, no frequent urination

Musculoskeletal: No bone/joint symptoms, no weakness, no muscle pain

Respiratory: No cough, no shortness of breath, no wheezing, no excessive snoring

Reproductive: No penile discharge, no sexual difficulties

Blood: No bleeding, no easy bruising

Cardiovascular: No chest pain, no irregular heartbeat

Metabolic/Endo: No cold intolerance, no heat intolerance, no excess thirst, no excess hunger

Immunological: No environmental allergies, no food allergies.

Vascular: No calf pain with walking

Neuro: No difficulty walking, no headaches, no numbness tingling in extremities

Psychiatric: No depression, no sleep disturbances, no anxiety, no racing thoughts, no hearing voices

**FEMALE REVIEW OF SYSTEMS**

General: No fatigue, no fever, no night sweats, no unintentional weight loss or gain

GI: No abdominal pain, no constipation, no diarrhea, no vomiting

Skin: No itching, no rash

Ears nose throat: No ear drainage, no hearing loss, no nasal drainage, no sore throat, no dry mouth, no mouth lesions

Eyes: No eye discharge, no blurred vision, no eye pain, no vision changes

Urinary: No pain with urination, no bloody urine, no frequent urination

Musculoskeletal: No bone/joint symptoms, no weakness, no muscle pain

Respiratory: No cough, no shortness of breath, no wheezing, no excessive snoring

Reproductive: No vaginal discharge, no painful periods, no excess bleeding, no pain with intercourse, no decreased libido

LAST MENSTRUAL PERIOD DATE: \_

Blood: No bleeding, no easy bruising

Cardiovascular: No chest pain, no irregular heartbeat

Metabolic/Endo: No cold intolerance, no heat intolerance, no excess thirst, no excess hunger

Immunological: No environmental allergies, no food allergies.

Vascular: No calf pain with walking

Neuro: No difficulty walking, no headaches, no numbness tingling in extremities

Psychiatric: No depression, no sleep disturbances, no anxiety, no racing thoughts, no hearing voices

**PHYSICAL EXAM**

General: Alert and oriented, well nourished, no acute distress  
Eye: Normal conjunctiva, no pallor  
HENT: Normocephalic, normal hearing, moist oral mucosa, no sinus tenderness  
Neck: Supple, non-tender, no carotid bruits, no JVD, no lymphadenopathy  
Resp: Clear to auscultation bilaterally, non-labored respirations, nontender, absence of wheezing, rhonchi and crackles, no cyanosis  
CV: Normal S1/S2, normal rate, regular rhythm, no murmurs/rubs/gallops, no edema, no pulsus tardus et parvus  
Abd: Soft, nontender, nondistended, no hepatosplenomegaly, NBS  
Back: No CVA tenderness  
Musculoskeletal: Normal range of motion and strength, normal tone, no tenderness or swelling  
Integumentary: Warm, dry and pink, no rashes or lesions  
Neuro: Awake, alert and oriented X3, sensation intact in all four extremities  
Psychiatric: Cooperative, appropriate mood and affect, no flat affect

**WELL-MAN TEMPLATE**

Counseling: Encouraged healthy diet. Goal 30 min 5 times a week exercise.

Tobacco and Alcohol use reviewed

Depression screening performed

High risk behaviors screening done

Risk factor evaluation:

- vaccines recommended -> Flu vaccine\_ Tetanus/TDAP\_ Pneumovax 23/Prevnar 13\_ Zostavax/Shingrix\_

Anticipatory guidance:

- Yearly physicals

- USPSTF recommends a one-time ultrasound screening for abdominal aneurysm in men age 65-75 who have ever smoked\_

- Periodic cholesterol lab test if age >35 or age 20 to 34 with cardiac risk factors

- Colon cancer screening (colonoscopy or FIT cards)\_

- Prostate cancer screening - discussed the following with patient regarding PSA screening. An elevated PSA does not necessarily indicate prostate cancer. Could be elevated for other reasons like infection or enlarging size. If elevated options are to monitor, if higher level then biopsy, or directly go to biopsy. Negative biopsy does not entirely rule out prostate cancer and most older men will not die from the disease. Is difficult to tell even with biopsy if aggressive or not. Treatments for prostate cancer may cause impotence, incontinence, and pain. Patient studies have not demonstrated mortality reduction with PSA screening. ­\_

-Low dose CT chest in previous 30 pack year smokers (age 55-80): \_

-Screening for HIV in adolescents and adults age 15-65

-Screening for Hepatitis C in all adults born between 1945-1965

**MEDICARE WELLNESS EXAM TEMPLATE MALE**

Patient is here for a Medicare Annual Wellness Visit. The patient's last visit was: \_

Past medical/surgical history was reviewed and includes: \_

In addition to myself, the patient sees the following medical providers: \_

Medications, including supplements, were reviewed.

Use of opioids/controlled substances reviewed.

Patient has established medical power of attorney and advanced directive. \_

Family and social history were reviewed.

Prior/current tobacco, alcohol, and drug use reviewed.

Nutrition: Diet and nutrition were reviewed and are appropriate.­ \_

Sleep: No sleep issues.

Exercise: Regimen reviewed and appropriate.­ \_

Pt denies feeling down, depressed or loss of interest in past 2 weeks. \_

Pt denies having any concerns about hearing or vision.

Pt is independent in all ADLS and IADLS, except: \_

Pt's home does not have rugs in hallways or grab bars in bathroom. Lighting adequate and handrails for stairs where applicable.

Pt uses the following assistive devices: none.

Up & Go test is steady and <30 seconds.

Cognitive Screen negative. \_

Colonoscopy: \_

Prostate cancer screening - discussed the following with patient regarding PSA screening. An elevated PSA does not necessarily indicate prostate cancer. Could be elevated for other reasons like infection or enlarging size. If elevated options are to monitor, if higher level then biopsy, or directly go to biopsy. Negative biopsy does not entirely rule out prostate cancer and most older med will not die from the disease. Is difficult to tell even with biopsy if aggressive or not. Treatments for prostate cancer may cause impotence, incontinence, and pain. Patient studies have not demonstrated mortality reduction with PSA screening. ­\_

AAA Screen (once age 65 with history of smoking): \_

Low dose CT chest in previous 30 pack year smokers (age 55-80): \_

-Screening for HIV in adolescents and adults age 15-65

-Screening for Hepatitis C in all adults born between 1945-1965

Vaccines:

Td \_ or Tdap \_

Flu \_

Prevnar 13 \_

Pneumovax \_

Zostavax/Shingrix\_

Health Risk Assessment reviewed and to be scanned.

**WELL-WOMAN EXAM**

Counseling: Encouraged healthy diet. Goal 30 min 5 times a week exercise.

Tobacco and Alcohol use reviewed

Depression screening performed

High risk behaviors screening done

Risk factor evaluation:

- vaccines recommended -> Flu vaccine\_ Tetanus/TDAP\_ Pneumovax 23/Prevnar 13\_ Zostavax\_

Anticipatory guidance:

- Yearly physicals

- Pap smear/pelvic exam \_

- Mammogram \_

- Bone Density scan \_

- Colon cancer screening (colonoscopy or FIT cards)\_

- Periodic cholesterol lab test if age > 45 or age 35 to 45 with cardiac risk factors

Low dose CT chest in previous 30 pack year smokers (age 55-80): \_

-Screening for HIV in adolescents and adults age 15-65

-Screening for Hepatitis C in all adults born between 1945-1965

**MEDICARE WELLNESS EXAM TEMPLATE FEMALE**

Patient is here for a Medicare Annual Wellness Visit. The patient's last visit was: \_

Past medical/surgical history was reviewed and includes: \_

In addition to myself, the patient sees the following medical providers: \_

Medications, including supplements, were reviewed.

Use of opioids/controlled substances reviewed.

Patient has established medical power of attorney and advanced directive. \_

Family and social history were reviewed.

Prior/current tobacco, alcohol, and drug use reviewed.

Nutrition: Diet and nutrition were reviewed and are appropriate.­ \_

Sleep: No sleep issues.

Exercise: Regimen reviewed and appropriate.­ \_

Pt denies feeling down, depressed or loss of interest in past 2 weeks. \_

Pt denies having any concerns about hearing or vision.

Pt is independent in all ADLS and IADLS, except: \_

Pt's home does not have rugs in hallways or grab bars in bathroom. Lighting adequate and handrails for stairs where applicable.

Pt uses the following assistive devices: none.

Up & Go test is steady and <30 seconds.

Cognitive Screen negative. \_

Pap smear/pelvic exam: \_

Mammogram: \_

Colonoscopy: \_

Bone Density Scan(age 65, younger if higher risk): \_

Low dose CT chest in previous 30 pack year smokers(age 55-80): \_

-Screening for HIV in adolescents and adults age 15-65

-Screening for Hepatitis C in all adults born between 1945-1965

Vaccines:

Td \_ or Tdap \_

Flu \_

Prevnar 13 \_

Pneumovax \_

Zostavax/Shingrix \_

-Screening for HIV in adolescents and adults age 15-65

-Screening for Hepatitis C in all adults born between 1945-1965

Health Risk Assessment reviewed and to be scanned.

**TRANSITIONAL CARE APPOINTMENT**

Just make sure to copy the entire pharmacy note into your HPI

**ADVANCED CARE PLANNING**

Total Time spent(minutes):  
Patient/Family agreed to discuss end of life issues and given opportunity to decline  
This discussion included: patient (enter other family members here and does not need to include patient if they are unable)  
Content/Goals: (What discussed, understanding of illness, spiritual factors, why making decisions)  
Advanced directive: filled out/given to patient/patient does not want at this time

**NEW NARCOTIC PLAN**

We are prescribing you an opioid pain medicine and utilize the Arizona Opioid Prescribing Guidelines. They are not first line treatment for mild or moderate acute pain. If indicated, we want to use the lowest effective dose for no longer than 3-5 days then reassess.

The CSPMP database has been reviewed and appropriate

Side effects of narcotics include constipation, nausea, vomiting, rash, breathing problems, confusion, falls, memory loss, itching, sleepiness, hormonal changes, urinary retention, infection, addiction, death and other risks.

We can give you a prescription of naloxone in case of overdose, but this may still not prevent deaths or disability. Given\_ Does not want\_

Do not use more than prescribed or mix with other narcotics or recreational drugs.

The use of benzodiazepines like Xanax and Ativan greatly increases the risks.

If pregnant this can affect the baby negatively.

Ensure your medicine is stored in a safe place and you cannot drive while on opioids.

**RENEWAL NARCOTIC PLAN**

We are refilling your opioid pain medicine and utilize the Arizona Opioid Prescribing Guidelines. Stable, chronic pain syndrome. No evidence of escalating use, abuse, or addiction. Tolerating current regimen well with no reported side effects and good functional status.

The CSPMP database has been reviewed and appropriate

Chronic use of opioids reviewed including side effects and long-term harms. Side effects include constipation, nausea, vomiting, rash, breathing problems, confusion, falls, memory loss, itching, sleepiness, hormonal changes, urinary retention, infection, addiction, death and other risks.

Do not use more than prescribed or mix with other narcotics.

The use of benzodiazepines like Xanax and Ativan greatly increases the risks.

If pregnant this can affect the baby negatively.

Ensure your medicine is stored in a safe place and you cannot drive while on opioids if impaired.

We may perform random Urine drug testing to ensure proper use.

Controlled substance contract on chart reviewed and current. Patient understands that no early refills can be given for any reason, and that no pain medications can be obtained from other providers.

Continue multimodal treatment approach.

Naloxone prescription and education for use in overdose provided

**CHRONIC PAIN HPI Autotext:**

Patient presents today for follow up chronic pain on opioid therapy.   
  
IMC Pain Contract Date: \_  
IMC Pain Contract Provider: \_  
  
Indication: \_  
Prescription and Dosage: \_  
Calculated Daily MME: \_  
Last UDS date and results: \_  
  
Previous treatments: \_  
Current treatment for pain also includes: \_  
  
Pain symptoms/description: \_  
Interval changes: \_  
  
Amount currently taking: \_  
  
Medication side effects: \_  
Adequacy of pain control: \_  
Functional status: \_  
  
Controlled substance prescriptions from other providers:\_  
Alcohol use: \_  
Recreational drug use: \_  
Mood symptoms: \_  
  
Would like to \_continue at current dosage \_make changes as follows: \_.

**Stable Chronic Opioid Use Plan:**

Stable, chronic pain syndrome. No evidence of escalating use, abuse, or addiction. Tolerating current regimen well with no reported side effects and good functional status.

PMP reviewed and appropriate. Last UDS reviewed and \_ consistent. Mood screening: \_. Substance use screening: \_.

-Chronic opioid use reviewed with patient including side effects and long-term harms.

-Rx for \_ provided; #\_ days, to be filled on \_.

-Controlled substance contract on chart reviewed and current. Patient understands that no early refills can be given for any reason, and that no pain medications can be obtained from other providers.

-Continue multimodal treatment approach as above.

-Return to clinic for dedicated chronic pain visit in \_ with \_.

- Naloxone prescription and education for use in overdose provided

**Narcotic Patient Plan Autotext:**

You have been given a \_-day supply of your pain medications.

Please make an appointment with Dr. \_ in \_ for your next visit for refills.

Reminders:

- Please make every effort to see the same physician for refills whenever possible

- Early refills will not be given for any reason

- Requests for pain medication refills must be scheduled during a separate visit

- Your opioid contract with our clinic may be cancelled at any time if you obtain opioid pain medications from any other clinic or health care location, or if you use illegal drugs

**CIRRHOSIS**

MELD =

Child-Pugh =

-Step 1 diuretics for ascites prevention: 100mg spironolactone and 40mg furosemide

-Monitor for spontaneous bacterial peritonitis

-Recommend close follow-up with an alcohol cessation program, such as Alcoholic Anonymous

-If sobriety is maintained, follow-up with hepatology for evaluation for liver transplant

-Maintain sodium restriction, 2-3g/day

-Continue lactulose for prevention of PSE. Avoid other sedatives, such as narcotics and benzodiazepines to prevent worsened encephalopathy

-If viral hepatitis present, follow-up for treatment with agents such as Harvoni

-Provide vaccinations for hepatitis A and B if not immune

-Avoid hepatotoxins. Avoid NSAIDs or >3g/day of acetaminophen

-Recommend surveillance ultrasound for HCC every 6 months

-Avoid PPIs unless there is a known indication, as they increase the risk of SBP

-Recommend outpatient surveillance endoscopy to rule-out esophageal varices

-For small varices with red signs and/or Child B or C cirrhosis and for all patients with medium or large varices, recommend prophylactic treatment with a 40mg nadolol daily (if blood pressure can tolerate)

-In patients with large varices, treatment with endoscopic variceal ligation is recommended rather than a nonselective beta blocker

**DEPRESSION (OTHER CAUSES)**

Depression:

Use of hypnotics:

Use of B-blocker:

Drug abuse/withdrawal:

Adrenal insufficiency (normal BP/K+):

Cancer screening up to date?:

Sleep apnea:

Hours of sleep per night:

CBC (anemia):

TSH:

Vitamin D:

**DEPRESSION**

Depression is a brain disease that makes you sad, but it is different than normal sadness (figure 1). Depression can make it hard for you to work, study, or do everyday tasks.

-Many people who take medicines for depression start to feel better within 2 weeks, but it might be 4 to 8 weeks before the medicine has its full effect.

-Many people who see a counselor start to feel better within a few weeks, but it might take 8 to 10 weeks to get the greatest benefit.

See someone right away if you want to hurt or kill yourself. — If you ever feel like you might hurt yourself or someone else, do one of these things:

-Call your doctor or nurse and tell them it is urgent

-Call for an ambulance (in the US and Canada, dial 9-1-1)

-Go to the emergency room at your local hospital

-Call the National Suicide Prevention Lifeline:

•1-800-273-8255

•www.suicidepreventionlifeline.org

**DIABETES**

-A1c every 3 months

-CMP yearly

-Lipid panel every 5 years

-Urine spot microalbumin every 6 months

ACEI use if albuminuria present

-Diabetic eye exam every year

-Diabetic foot exam at routine visits

Advised patient on the importance of protective footwear. Avoid going barefoot. Wash and check feet daily.

-Moderate intensity statin and baby aspirin use recommended

-Nutritionist referral discussed

-Diabetic shared medical visit discussed

-Educated patient on the importance of a low sugar diet and exercise

**ANTICIPATORY GUIDANCE**

Anticipatory guidance:

-Yearly physicals

-Vaccines:

-Shingles- 60.

-Pneumonia- 65.

-Flu- yearly.

-TD- every 10yrs.

-Pap- every 3-5yrs.

-Dexa- postmenopause or 65

-Colonoscopy: age 50 (or 10yr prior to 1st degree relative).

-HIV screening: once in lifetime age 15-65

-HepC screening if born between 1945-1965 1x

-If smoker:

--1x abd US for men 65-75

--Annual CT 55-80yo or quit within last 15yrs

--Pneumococcal for all ages

--ASH LINE: 1800-55-66-222

**ALCOHOL COUNSELING**

Counseling: alcohol no more than 1 drink per sitting or 7 drinks per week. Healthy diet and exercise. Advance directives discussed. Vitamin D use.

**FEMALE RISK FACTOR EVALUATION**

Risk factor eval:

-Pap and breast exam to be completed:

-Mammogram: Hasn't had one in many yrs; due.

-Labs:

-Vaccines recommended: flu yearly.

-ASCVD risk:

**HEART FAILURE RECOMMENDATIONS (LVEF ≤40 percent)**

Loop diuretics if volume overload

ACEI or ARBs to optimize diuretic therapy and control BP

ARNI (sacubutril-valsartan) instead of ACEI/ARB if symptoms despite optimized therapy

If cannot tolerate ACEI/ARB, hydralazine + isosorbide dinitrate is an option

B-blocker after ACEI, starting at low dose.

LVEF ≤35 percent in sinus rhythm with a resting HR ≥70 + on maximum tolerated dose of B-blocker (OR CI to beta-blocker): suggest ivabradine

LVEF <35%, start spironolactone (or <40% post-STEMI). K+ must be <5, GFR >30.

Digoxin if symptomatic despite B-blocker, ACEI, spironolactone and extra diuretic

AICD recommended if EF <35%

Lifestyle modifications discussed in detail with patient: quitting smoking/alcohol/drug use, 2-3g/day sodium restriction, weight loss, and daily weight monitoring.

**PERIPHERAL NEUROPATHY DIFFERENTIAL/TREATMENT**

Peripheral neuropathy

-Neuropathy is the medical term for nerve damage.

Differential is broad and includes

-Diabetic polyneuropathy

-Infectious: HIV-associated neuropathy: a/w didanosine, stavudine. Syphilis. Lyme disease.

-Hereditary, such as Charcot-Marie Tooth

-Autoimmune, such as Guilliane Barre

-Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

-Toxins: chemotherapy (platinum drugs), alcohol, uremia

-Amyloidosis

Initial testing includes electrodiagnostic studies and EMG, if not clear cut explanation.

Lab testing should include:

-Vitamin B12 and folate levels

-TSH

-BMP

-SPEP and UPEP

-RPR

-A1c

-ESR

-Consider, if all above negative: urine heavy metals, urine porphyrins, RF, Sjogren's, Lyme Ab, HIV, Hu antibody, MMA, homocysteine, hepatitis B/C

-Skin biopsy for evaluation of small fibers if normal EMG

Treatment:

-Gabapentin or pregabalin

-Amitriptyline or nortriptyline (starting at 10 mg at bedtime and increase as tolerated to 75 to 100 mg based on symptomatic improvement). Other potential agents include venlafaxine (37.5 to 225 mg/day) and duloxetine (60 mg/day).

-Topical agents such as lidocaine or capsaicin (the active ingredient in hot chili peppers) are applied directly over the affected painful site

-Opioids, such as tramadol (50 to 100 mg three times daily), oxycodone morphine, or fentanyl patch may need to be added to the above mentioned therapies for breakthrough pain or to control recalcitrant symptoms.

-Alpha-lipoic acid (ALA) is an antioxidant medication available without a prescription as a dietary supplement. It is usually taken by mouth once per day.

**BACK PAIN**

-Use of heat, massage therapy, and exercise discussed

-Use of acupuncture and spinal manipulation discussed

-Meditation and mindfulness recommended

-Physical therapy recommended

-Ibuprofen and Tylenol use discussed

-Extensive education on conservative therapies and the natural course of back pain discussed

**CHRONIC CHEST PAIN**

-Education regarding chest pain given

-Physical conditioning and exercise discussed

-A diet low in saturated and trans-unsaturated fatty acids and a reduced caloric intake to achieve optimal body weight recommended

-Cigarette smoking was discouraged

-Keep a diary of your chest pain episodes and bring to the office during the next visit

Aggressive control of the dyslipidemia (target LDL cholesterol <70 mg/dL):

Hypertension (target blood pressure 120/80 mmHg):

Nitroglycerin sublingually 0.4 or 0.6 mg.

Take the medication both to relieve chest pain and also approximately 5 min before stress that is likely to induce an episode.

B-blocker (if not, CCB):

Baby aspirin:

ACE inhibitor:

**INR CHECK**

-Patient has been taking warfarin since

-Reason for warfarin therapy:

-Warfarin dosing schedule:

-Patient asserts they are following the proper diet:

-Patient has questions about proper diet?:

-Recent change to any medications since last visit?

-Does patient have any bleeding/bruising?

-Any hospitalization since last INR check?

-Is patient taking OTC medications?

-Is patient taking a multivitamin?

-Does patient have a dental procedure or surgery in near future?

-Expected duration of warfarin therapy:

-Patient’s questions about warfarin therapy answered:

**SLEEP HYGIENE**

Sleep hygiene — Sleep hygiene refers to actions that tend to improve and maintain good sleep

-Sleep as long as necessary to feel rested (usually seven to eight hours for adults) and then get out of bed

-Maintain a regular sleep schedule, particularly a regular wake-up time in the morning

-Try not to force sleep

-Avoid caffeinated beverages after lunch

-Avoid alcohol near bedtime (eg, late afternoon and evening)

-Avoid smoking or other nicotine intake, particularly during the evening

-Adjust the bedroom environment as needed to decrease stimuli (eg, reduce ambient light, turn off the television or radio)

-Avoid prolonged use of light-emitting screens (laptops, tablets, smartphones, ebooks) before bedtime

-Resolve concerns or worries before bedtime

-Exercise regularly for at least 20 minutes, preferably more than four to five hours prior to bedtime

-Avoid daytime naps, especially if they are longer than 20 to 30 minutes or occur late in the day

**DIZZINESS**

Onset:

Triggers/Trauma:

*Single Most important Question:*

Do you feel like your dizzy sensation comes from your head or your feet?

*(Helps separate disequilibrium from sensory deficits from neurological etiology in patients with DM.  If “feet” then disequilibrium is most likely.)*

*Vertigo*

Do you feel like the room is spinning or that you are moving when you are not? *(If yes, vertigo likely)*

Are your symptoms worsened by positional changes? *(Peripheral vertigo)*

Any hearing loss or tinnitus? *(Peripheral vertigo)*

How often are you having dizziness?

Do you have any other symptoms at the same time as the dizziness?

Headache? (points to central vertigo but is not pathognomonic)

Has the onset of these other symptoms been gradual or sudden?

*(Gradual points to central, more sudden and severe to peripheral)*

Do the symptoms come and go? *(Peripheral)* Are they continuous? *(Central)*

*Presyncope*

Do you have a history of fainting or loss of consciousness?

Do you have a family history of sudden cardiac death or cardiac arrythmias?

Do you have a history of heart problems?

*Yes to any of these points to presyncope/syncope.*

What medications do you take?

Any new medications, OTC medications or herbal supplements?

How much water are you drinking?

*Disequilibrium*

Do you have diabetic neuropathy?

Do you have any known musculoskeletal disorders?

Please describe what you mean by “dizzy” *(helps with nonspecific dizziness)*

What else do you have going on in your life right now?

Do you have any other symptoms at the same time as the dizziness?