Medical Decision Making

Patient history and symptoms
Patient name:
Date of birth:
Gender:
Date:
Chief complaint
Describe the patient's main concern or presenting problem:
Clinical history and presenting problem
History of present illness:
Summarize onset, duration, severity, and context of the problem.
Past medical history:
Describe previous diagnoses, surgeries, or chronic conditions.
Family history:
Include relevant familial diseases or genetic conditions.
Social history (e.g., lifestyle, occupation):
Describe factors like smoking, alcohol use, or occupational risks.

Medications and allergies

Current medications:

List prescribed and over-the-counter medications, including dosage and frequency

Allergies:

List known allergies and reactions, including medications, foods, or environmental triggers

Physical examination

General vital signs:

Temperature: ◯ °C ◯ °F

Heart rate: bpm

Blood pressure: / mmHg

Respiratory rate: /min

Oxygen saturation: %

General appearance:

Describe the patient's overall presentation, e.g., "Alert and oriented, pale appearance"

Additional notes

Describe any other relevant findings from the physical examination/texts specific to the presenting problem:

Test results	
Recent tests:	
Summarize completed diagnostic tests and results	
Pending tests:	
List tests ordered but not yet completed	
Medical decision-making level	
Level of medical decision-making	○ N/A ○ Low ○ Moderate ○ High
Amount and/or complexity of data reviewed and analyzed	○ Limited ○ Moderate ○ Extensive
Risk of complications and/or morbidity or mortality	○ N/A ○ Minimal ○ Low ○ Moderate ○ High

Interpretation and next steps
Summarize key findings and their significance, detail next steps.
Patient/family communication notes
Record discussions with the patient or family, including questions or concerns addressed
Team communication notes
Summarize communication with other healthcare team members
Healthcare professional:
Signature: **Date**: