

**Bravo Health Marfa**

105 E Oak St  
Marfa, TX 79843  
P: (432) 729-3000 | F:(432) 729-3001

**Referral Form**

Referring to: VICTORIA DO, MD

Referred from: RACHEL MENGES, MSN, APRN, FNP-BC

**Patient Information:**

Patient:2yyttest 2yyttest      DOB: 01/02/1985      Sex: Female

Patient Address: 107 West Ave  
Valdosta GA 31605      Patient Phone: (555)-555-5555

Patient Diagnosis: ICD10: M25.561 - Pain in right knee; ICD10: R05.3 - Chronic cough

**Reason for Referral:**  
evaluate and treat for

**Additional Referral Notes:**

**Insurance Information:**

Authorization #:

# of Visits:

Expiration Date:

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**Referral Form****Referring to:** Dr. Smith**Referred from:** DANIELLE OLSZESKI, PA**Patient Information:****Patient:** 2yyttest 2yyttest      **DOB:** 01/02/1985      **Sex:** Female**Patient Address:** 107 West Ave  
Valdosta GA 31605      **Patient Phone:** (555)-555-5555**Patient Diagnosis:** ICD10: M25.561 - Pain in right knee; ICD10: R05.3 - Chronic cough**Reason for Referral:**

evaluate and treat for refer to ENT for chronic sinusitis (J32.8)

**Additional Referral Notes:****Insurance Information:**Authorization #: # of Visits: Expiration Date:

**MEMORIAL HERMANN®**  
**OnSite Clinic**  
 IN ASSOCIATION WITH **Hamilton Health Box**



**HAMILTON**  
**HEALTH BOX**

Previously Electronically Signed by: DANIELLE OLSZESKI on 12/11/2025 09:30 AM CST  
 Electronically Signed by: DANIELLE OLSZESKI on 01/02/2026 04:10 PM CST

**Patient Demographics**

Patient Name: 2yyttest 2yyttest  
 Date of Birth: 01/02/1985  
 Gender: Female  
 Preferred Language: English

Bill Type:  
 Primary Insurance:

INSURANCE  
 Blue Cross and Blue Shield of Texas

**Care Team**  
 Rendering Provider: DANIELLE OLSZESKI, PA

**Date and Location of Visit**

Date of Service: 12/11/2025  
 Chart Number: H-B1A9  
 Location: BHPRESIDIO

**Medication Summary**

**Drug Allergies**  
 No Known Drug Allergies

**Current Medications**  
 Tylenol (acetaminophen) tablet 325 mg

**Medication Reconciliation:**  
 Not performed

**Chief Complaint / Assistant Note**  
 Pt 2yyttest, a 40 y.o. Female, presents with .

**Subjective**

**HPI**

What brings you in today?  
 → "What's going on?" or "What are you being seen for today?"

When did it start?  
 → Days, weeks, etc.

Where is it located?  
 → Be specific: "left knee," "lower back," etc.

What does it feel like?  
 → Sharp, dull, pressure, Itchy, etc.

Has it gotten better, worse, or stayed the same?

Any other symptoms?  
 → Fever, nausea, cough, swelling, etc.

Have you done anything to treat it so far?  
 → Medications, ice/heat, rest, ER/urgent care, home remedies

**Medical History- Adult**

**Past Medical History:**  None

<input type="checkbox"/> ADHD	<input type="checkbox"/> COPD	<input type="checkbox"/> Irritable Bowels	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Urinary Tract Infection
<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Depression	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Amputation	<input type="checkbox"/> Dementia	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Seizures	<input type="checkbox"/>
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Gastrointestinal Disorder(s)	<input type="checkbox"/> Kidney Stone	<input type="checkbox"/> Sinus Issues	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> GERD	<input type="checkbox"/> Lung Disorder(s)	<input type="checkbox"/> Skin Problems	<input type="checkbox"/>
<input type="checkbox"/> Autoimmune Disorder(s)	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Memory Impairment	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/>
<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> STI	<input type="checkbox"/>
<input type="checkbox"/> Blood Disorder(s)	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Stroke	<input type="checkbox"/>
<input type="checkbox"/> Cataract	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/>
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Hypotension	<input type="checkbox"/> OB-GYN Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcer	<input type="checkbox"/>

**FAMILY MEDICAL HISTORY**  family history unknown

Mother	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease/Heart Attack	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Cancer
(Type)							
Father	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease/Heart Attack	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Cancer
(Type)							
Siblings	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease/Heart Attack	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Cancer
(Type)							
Family (Other)	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease/Heart Attack	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Cancer
(Type)							

**Social History:**

Occupation:  Retired  Disabled  Student  Homemaker  Unemployed  Self-Employed  Employed Full-Time  Employed Part-Time

Marital Status:  Single  Married  Divorced  Widow/Widower  Domestic Partner  In a long-term relationship

Number of Children: Do you live alone?  Yes  No

Alcohol:  Yes  No Amount:  Social Drinker  NON DRINKER

Substance Abuse:  Yes  No Type:

Do you exercise regularly?  Yes  No \*\*If yes, what type and how often?

Special Diet?

Are you a smoker?  Yes  No Have you ever been a smoker?  Yes  No

If yes, Age Started Smoking Age Stopped PPD

Are you an E-Cigarette User  Yes  No Do you use smokeless tobacco?  Yes  No

Sexually Active

**SURGICAL HISTORY**  No surgical history

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cesarean	<input type="checkbox"/> Breast Biopsy	<input type="checkbox"/> CABG	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> EGD	<input type="checkbox"/> Mastectomy <input type="checkbox"/> Lumpectomy	<input type="checkbox"/> Cardiac Cath	<input type="checkbox"/> Thyroidectomy
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Circumcision	<input type="checkbox"/> Knee Surgery	<input type="checkbox"/> Pacemaker/Defibrillator	<input type="checkbox"/> Splenectomy
<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Hip Surgery	<input type="checkbox"/> Ear Tubes	<input type="checkbox"/> Carotid Endarterectomy
<input type="checkbox"/> D&C	<input type="checkbox"/> Bladder Surgery	<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Tonsils/Adenoids	<input type="checkbox"/> Other

What Kind?	Where was it done?	When?

Specialists:  None

Specialty	Frequency	Last Visit	Next Visit	Comment/Reason


Hospitalizations or Other Medical Problems:  None

Why?	Where?	When?

**HEALTH MAINTENANCE**

<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> COLOGUARD	<input type="checkbox"/> FOBT (Date):	<input type="checkbox"/> Chest XRAY (Date):
<input type="checkbox"/> Screening Mammogram (Date):		<input type="checkbox"/> Low dose CT chest (lung cancer screening) (Date):	
<input type="checkbox"/> PAP smear (Date):		<input type="checkbox"/> Eye Exam (Date):	
<input type="checkbox"/> DEXA scan (Date):		<input type="checkbox"/> TB skin test (Date):	

**Gynecology History- Women only:** n/a

Date of last menstrual period: Menopause? Currently Pregnant? . Breastfeeding

G: P: M: A:

Method of Contraceptive:

**Immunization History:**

Pneumonia Vaccination: Date: ; Date:

Shingrix Vaccination: 1st: 2nd:

TD: Date:

Ttu: Date:

Other:

**End of Life Plan:**

Advanced Directives?

Living Will?

Medical Power of Attorney? Name: Relationship:

DNR? Filed Where?

**Problem History**

ICD-10	ICD-9	Description	Status	Diagnosed	EDU	COG	Funct.	Diagnosed by	Resolved by
ICD10 I32.8	I20.0	Other chronic sinusitis	ACTIVE	12/11/2025 09:06 AM CST	No	No	No	DANIELLE OLSZEWSKI	N/A
ICD10 I20.0		Calcium of kidney	ACTIVE	12/11/2025 09:06 AM CST	No	No	No	DANIELLE OLSZEWSKI	N/A
ICD10 J98.8		Other specified respiratory disorders	ACTIVE	12/08/2025 03:27 PM CST	No	No	No	RACHEL MENGES, FNP-BC	N/A
ICD10 J45.20		Mild intermittent asthma, uncomplicated	ACTIVE	12/08/2025 12:00 AM CST	No	No	No	RACHEL MENGES, FNP-BC	N/A
ICD10 Z00.00		Encntr for general adult medical exam w/o abnormal findings	ACTIVE	11/12/2025 03:39 PM CST	No	No	No	DANIELLE OLSZEWSKI	N/A

**ROS**

REVIEW OF SYSTEMS	
SYSTEMS	WNL ABNORMAL
GENERAL	<input type="checkbox"/> WEIGHT CHANGE <input type="checkbox"/> FATIGUE <input type="checkbox"/> FEVER <input type="checkbox"/> CHILLS <input type="checkbox"/> NIGHT SWEATS <input type="checkbox"/> DECREASED ENERGY LEVEL <input type="checkbox"/> RECENT ILLNESS <input type="checkbox"/> WEAKNESS <input type="checkbox"/> INSOMNIA <input type="checkbox"/> SWEATING <input type="checkbox"/> NOCTURNAL COUGH
SKIN	<input type="checkbox"/> DELAYED HEALING <input type="checkbox"/> RASH <input type="checkbox"/> BRUISING <input type="checkbox"/> BLEEDING <input type="checkbox"/> SKIN DISCOLORATION <input type="checkbox"/> CHANGE IN SKIN LESION/MOLE <input type="checkbox"/> LUMP <input type="checkbox"/> BUMP <input type="checkbox"/> SKIN LESION <input type="checkbox"/> SORE <input type="checkbox"/> INSECT BITE
HEAD	<input type="checkbox"/> HEADACHES <input type="checkbox"/> ITCHY SCALP <input type="checkbox"/> RECENT HEADINJURY <input type="checkbox"/> CONCUSSION
EYES	<input type="checkbox"/> BLURRED VISION <input type="checkbox"/> CHANGE IN VISION <input type="checkbox"/> DISCHARGE <input type="checkbox"/> EYE PAIN <input type="checkbox"/> PHOTOPHOBIA <input type="checkbox"/> EYE REDNESS
EAR	<input type="checkbox"/> EAR PAIN <input type="checkbox"/> HEARING LOSS <input type="checkbox"/> RINGING IN EAR <input type="checkbox"/> DISCHARGE <input type="checkbox"/> HEARING AID
NOSE/MOUTH/THROAT	<input type="checkbox"/> SINUS CONGESTION <input type="checkbox"/> DYSPHAGIA <input type="checkbox"/> NOSE BLEED <input type="checkbox"/> NASAL DISCHARGE <input type="checkbox"/> DENTAL PAIN <input type="checkbox"/> HOARSENESS <input type="checkbox"/> SORE THROAT
BREAST	<input type="checkbox"/> N/A
HEME/LYMPH/ENDO	<input type="checkbox"/> LUMPS <input type="checkbox"/> BUMPS <input type="checkbox"/> CHANGES <input type="checkbox"/> HIV <input type="checkbox"/> BRUISING <input type="checkbox"/> HX OF BLOOD TRANSFUSION <input type="checkbox"/> NIGHT SWEATS <input type="checkbox"/> SWOLLEN GLANDS <input type="checkbox"/> INCREASE THIRST <input type="checkbox"/> INCREASE HUNGER <input type="checkbox"/> COLD INTOLERANCE <input type="checkbox"/> HEAT INTOLERANCE <input type="checkbox"/> ABNORMAL BLEEDING
CARDIOVASCULAR	<input type="checkbox"/> CHEST PAIN <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> PND <input type="checkbox"/> ORTHOPNEA <input type="checkbox"/> EDEMA <input type="checkbox"/> SWEATING WITH FEEDING <input type="checkbox"/> EXERCISE INTOLERANCE
RESPIRATORY	<input type="checkbox"/> COUGH <input type="checkbox"/> WHEEZING <input type="checkbox"/> HEMOPTYSIS <input type="checkbox"/> DYSPNEA <input type="checkbox"/> PNEUMONIA HX <input type="checkbox"/> TB <input type="checkbox"/> ASTHMA HX <input type="checkbox"/> PRODUCTIVE SPUTUM <input type="checkbox"/> HOME OXYGEN @LPM.
GASTROINTESTINAL	<input type="checkbox"/> NAUSEA <input type="checkbox"/> VOMITING <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> HEPATITIS <input type="checkbox"/> HEMORRHOIDS <input type="checkbox"/> EATING DISORDER <input type="checkbox"/> ULCER <input type="checkbox"/> BLACK TARRY STOOL <input type="checkbox"/> ABDOMINAL PAIN <input type="checkbox"/> BLOOD IN STOOL <input type="checkbox"/> GERD <input type="checkbox"/> HEARTBURN
GENITOURINARY/NEPHROLOGY	<input type="checkbox"/> URGENCY <input type="checkbox"/> FREQUENCY <input type="checkbox"/> BURNING <input type="checkbox"/> DYSURIA <input type="checkbox"/> CHANGE IN COLOR OF URINE <input type="checkbox"/> INCONTINENCE <input type="checkbox"/> DISCHARGE <input type="checkbox"/> BLOOD IN URINE <input type="checkbox"/> PAINFUL/SWOLLEN GENITAL AREA
GYNECOLOGICAL	<input type="checkbox"/> N/A <input type="checkbox"/> LMP
MUSCULOSKELETAL	<input type="checkbox"/> BACK PAIN <input type="checkbox"/> JOINT SWELLING <input type="checkbox"/> STIFFNESS <input type="checkbox"/> JOINT PAIN <input type="checkbox"/> FRACTURE HX <input type="checkbox"/> OSTEOPOROSIS <input type="checkbox"/> MUSCLE WEAKNESS <input type="checkbox"/> MYALGIA <input type="checkbox"/> FREQUENT FALLS <input type="checkbox"/> NECK PAIN <input type="checkbox"/> BACK PAIN
NEUROLOGICAL	<input type="checkbox"/> SYNCOP <input type="checkbox"/> SEIZURES <input type="checkbox"/> TRANSIENT PARALYSIS <input type="checkbox"/> WEAKNESS <input type="checkbox"/> PARESTHESIA <input type="checkbox"/> BLACK OUT SPELLS <input type="checkbox"/> SENSORY CHANGE <input type="checkbox"/> TINGLING <input type="checkbox"/> DIZZINESS <input type="checkbox"/> SPEECH CHANGE <input type="checkbox"/> HEADACHE <input type="checkbox"/> TREMORS <input type="checkbox"/> DIFFICULTY/TROUBLE SWALLOWING
PSYCHIATRIC	<input type="checkbox"/> DEPRESSION <input type="checkbox"/> ANXIETY <input type="checkbox"/> NERVOUS <input type="checkbox"/> SLEEPING DIFFICULTY <input type="checkbox"/> SUBSTANCE ABUSE <input type="checkbox"/> SUICIDAL IDEATIONS/ATTEMPTS <input type="checkbox"/> PREVIOUS DX <input type="checkbox"/> INSOMNIA <input type="checkbox"/> HALLUCINATIONS <input type="checkbox"/> DISTURBED SLEEP
ENDOCRINE	<input type="checkbox"/> INCREASE THIRST <input type="checkbox"/> INCREASE URINATION <input type="checkbox"/> HIGH BLOOD SUGAR <input type="checkbox"/> LOW BLOOD SUGAR
ADDITIONAL COMMENTS :	

**PHQ-2**

Little interest or pleasure in doing things in last 2 weeks

Feeling down, depressed, or hopeless in last 2 weeks

Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]

Select...

Select...

0

**Objective**

## Objective Notes

## Assessment

## Assessment Notes

Diagnosis Codes	Code	Description	Status	Diagnosed	Education	Cog	Func
ICD10	J32.8	Other chronic sinusitis	ACTIVE	12/11/2025	No	No	No
ICD10	N20.0	Calculus of kidney	ACTIVE	12/11/2025	No	No	No

## Procedure

## Procedure Notes

## Plan

## Plan Notes

Patient Referred Out and Summary of Care Provided: No

Clinical Summary Provided: No

## Referrals

Provider	Specialty	Description/Reason	DX Pointers
VALENCIA THOMAS, M.D.	None	(Code: ) refer to ENT for chronic sinusitis (Code: ) please refer to urology for kidney stone	J32.8 - Other chronic sinusitis N20.0 - Calculus of kidney

Lab Orders	Test Codes	Order Status	Created Date
DANIELLE OLSZESKI, PA	10231 - COMPREHENSIVE METABOLIC PANEL	ROUTINE	01/02/2026 09:10 AM CST

## Recalls

Provider	Location	Reason	Recall Date
ASHISH GUPTA, MD	BHMARFA	3 MONTH FOLLOW UP	02/11/2026

## Additional SOAP Comments

Electronically Signed by: DANIELLE OLSZESKI on 01/02/2026 04:10 PM CST

 Note generated by Azalea EHR - www.AzaleaHealth.com

**Bravo Health Marfa**

105 E Oak St  
Marfa, TX 79843  
P: (432) 729-3000 | F:(432) 729-3001

**Referral Form**

Referring to: Test Specialist

Referred from: DANIELLE OLSZESKI, PA

**Patient Information:**

Patient:2yyttest 2yyttest      DOB: 01/02/1985      Sex: Female

Patient Address: 107 West Ave  
Valdosta GA 31605      Patient Phone: (555)-555-5555

Patient Diagnosis: ICD10: M25.561 - Pain in right knee; ICD10: R05.3 - Chronic cough

**Reason for Referral:**

evaluate and treat for please refer to urology for kidney stone (N20.0)

**Additional Referral Notes:****Insurance Information:**

Authorization #:

# of Visits:

Expiration Date:

# MEMORIAL HERMANN<sup>®</sup>

## OnSite Clinic

IN ASSOCIATION WITH Hamilton Health Box



# HAMILTON

## HEALTH BOX

Electronically Signed by: DANIELLE OLSZESKI on 01/02/2026 04:11 PM CST  
Waiting for reviewer signature.

### Patient Demographics

Patient Name: 2yytest 2yytest  
Date of Birth: 01/02/1965  
Gender: Female  
Preferred Language: English

Bill Type:

SELF PAY (PATIENT)

### Care Team

Rendering Provider: MARITZA ARMENDARIZ

Reviewing Provider:

JAMES TARIN, MD

### Date and Location of Visit

Date of Service: NA  
Chart Number: HHB1A11  
Location: BHPRESIDIO

### Medication Summary

Drug Allergies  
No Known Drug Allergies

Current Medications  
Tylenol (acetaminophen) tablet 325 mg  
hydrochlorothiazide (hydrochlorothiazide) tablet 25 mg 1 tablet by mouth once a day [THIS IS A TEST PATIENT], 30 tablets

Medication Reconciliation:  
Not performed

### Chief Complaint / Assistant Note

Pt 2yytest, a Female, presents with .

### Subjective

#### HPI

What brings you in today?  
→ "What's going on?" or "What are you being seen for today?"

When did it start?  
→ Days, weeks, etc.

Where is it located?  
→ Be specific: "left knee," "lower back," etc.

What does it feel like?  
→ Sharp, dull, pressure, itchy, etc.

Has it gotten better, worse, or stayed the same?

Any other symptoms?  
→ Fever, nausea, cough, swelling, etc.

Have you done anything to treat it so far?  
→ Medications, ice/heat, rest, ER/urgent care, home remedies

### Medical History- Adult

Past Medical History:  None

<input type="checkbox"/> ADHD	<input type="checkbox"/> COPD	<input type="checkbox"/> Irritable Bowels	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Urinary Tract Infection
<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Depression	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Amputation	<input type="checkbox"/> Dementia	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Seizures	<input type="checkbox"/>
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Gastrointestinal Disorder(s)	<input type="checkbox"/> Kidney Stone	<input type="checkbox"/> Sinus Issues	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> GERD	<input type="checkbox"/> Lung Disorder(s)	<input type="checkbox"/> Skin Problems	<input type="checkbox"/>
<input type="checkbox"/> Autoimmune Disorder(s)	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Memory Impairment	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/>
<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> STI	<input type="checkbox"/>
<input type="checkbox"/> Blood Disorder(s)	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Stroke	<input type="checkbox"/>
<input type="checkbox"/> Cataract	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/>
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Hypotension	<input type="checkbox"/> OB-GYN Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcer	<input type="checkbox"/>

### FAMILY MEDICAL HISTORY

family history unknown

Mother	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease/Heart Attack	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Cancer (Type)
Father	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease/Heart Attack	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Cancer (Type)
Siblings	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease/Heart Attack	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Cancer (Type)
Family (Other)	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease/Heart Attack	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Cancer (Type)

### Social History:

Occupation:  Retired  Disabled  Student  Homemaker  Unemployed  Self-Employed  Employed Full-Time  Employed Part-Time

Marital Status:  Single  Married  Divorced  Widow/Widower  Domestic Partner  In a long-term relationship

Number of Children: Do you live alone:  Yes  No

Alcohol:  Yes  No Amount:  Social Drinker  NON DRINKER

Substance Abuse:  Yes  No Type:

Do you exercise regularly?  Yes  No \*\*If yes, what type and how often?

Special Diet?

Are you a smoker?  Yes  No Have you ever been a smoker?  Yes  No

If yes, Age Started Smoking Age Stopped PPD

Are you an E-Cigarette User  Yes  No Do you use smokeless tobacco?  Yes  No

Sexually Active

### SURGICAL HISTORY

No surgical history

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cesarean	<input type="checkbox"/> Breast Biopsy	<input type="checkbox"/> CABG	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> EGD	<input type="checkbox"/> Mastectomy <input type="checkbox"/> Lumpectomy	<input type="checkbox"/> Cardiac Cath	<input type="checkbox"/> Thyroidectomy
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Circumcision	<input type="checkbox"/> Knee Surgery	<input type="checkbox"/> Pacemaker/Defibrillator	<input type="checkbox"/> Splenectomy
<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Hemia Repair	<input type="checkbox"/> Hip Surgery	<input type="checkbox"/> Ear Tubes	<input type="checkbox"/> Carotid Endarterectomy
<input type="checkbox"/> D&C	<input type="checkbox"/> Bladder Surgery	<input type="checkbox"/> Dack Surgery	<input type="checkbox"/> Tonsils/Adenoids	<input type="checkbox"/> Other

What Kind?

Where was it done?

When?

Specialists:  None

Specialty Frequency Last Visit Next Visit Comment/Reason


Hospitalizations or Other Medical Problems:  None

Why?	Where?	When?

## HEALTH MAINTENANCE

<input type="checkbox"/> Colonoscopy <input type="checkbox"/> COLOGUARD <input type="checkbox"/> FOBT (Date):	<input type="checkbox"/> Chest XRAY (Date):
<input type="checkbox"/> Screening Mammogram (Date):	<input type="checkbox"/> Low dose CT chest (lung cancer screening) (Date):
<input type="checkbox"/> PAP smear (Date):	<input type="checkbox"/> Eye Exam (Date):
<input type="checkbox"/> DEXA scan (Date):	<input type="checkbox"/> TB skin test (Date):

## Gynecology History- Women only:

n/a  
 Date of last menstrual period: Menopause? Currently Pregnant? . Breastfeeding  
 G: P: M: A:

Method of Contraceptive:

## Immunization History:

Pneumonia Vaccination: Date: ; Date:  
 Shingrix Vaccination: 1st: 2nd:  
 TD: Date:  
 Flu: Date:  
 Other:

## End of Life Plan:

Advanced Directives?

Living Will?

Medical Power of Attorney? Name: Relationship:

DNR? Filed Where?

## Problem History

C.S.	Code	Description	Status	Diagnosed	Edu	Cop	Func	Diagnosed By	Resolved By
ICD10	R05.3	Chronic cough	ACTIVE	12/15/2025 03:52 PM CST	No	No	No	RACHEL MENGES, FNP-BC	N/A
ICD10	M25.551	Pain in right knee	ACTIVE	12/15/2025 03:52 PM CST	No	No	No	RACHEL MENGES, FNP-BC	N/A
ICD10	J32.8	Other chronic sinusitis	ACTIVE	12/11/2025 09:06 AM CST	No	No	No	DANIELLE OLSZEWSKI	N/A
ICD10	N20.0	Calculus of kidney	ACTIVE	12/11/2025 09:06 AM CST	No	No	No	DANIELLE OLSZEWSKI	N/A
ICD10	J98.8	Other specified respiratory disorders	ACTIVE	12/08/2025 03:27 PM CST	No	No	No	RACHEL MENGES, FNP-BC	N/A
ICD10	J45.20	Mild intermittent asthma, uncomplicated	ACTIVE	12/08/2025 12:00 AM CST	No	No	No	RACHEL MENGES, FNP-BC	N/A
ICD10	Z00.00	Encntr for general adult medical exam w/o abnormal findings	ACTIVE	11/12/2025 03:39 PM CST	No	No	No	DANIELLE OLSZEWSKI	N/A

## ROS

REVIEW OF SYSTEMS	
SYSTEMS	WNL/ABNORMAL
GENERAL	<input type="checkbox"/> WEIGHT CHANGE <input type="checkbox"/> FATIGUE <input type="checkbox"/> FEVER <input type="checkbox"/> CHILLS <input type="checkbox"/> NIGHT SWEATS <input type="checkbox"/> DECREASED ENERGY LEVEL <input type="checkbox"/> RECENT ILLNESS <input type="checkbox"/> WEAKNESS <input type="checkbox"/> INSOMNIA <input type="checkbox"/> SWEATING <input type="checkbox"/> NOCTURNAL COUGH
SKIN	<input type="checkbox"/> DELAYED HEALING <input type="checkbox"/> RASH <input type="checkbox"/> BRUISING <input type="checkbox"/> BLEEDING <input type="checkbox"/> SKIN DISCOLORATION <input type="checkbox"/> CHANGE IN SKIN LESION/MOLE <input type="checkbox"/> LUMP <input type="checkbox"/> BUMP <input type="checkbox"/> SKIN LESION <input type="checkbox"/> SORE <input type="checkbox"/> INSECT BITE
HEAD	<input type="checkbox"/> HEADACHES <input type="checkbox"/> ITCHY SCALP <input type="checkbox"/> RECENT HEADINJURY <input type="checkbox"/> CONCUSSION
EYES	<input type="checkbox"/> BLURRED VISION <input type="checkbox"/> CHANGE IN VISION <input type="checkbox"/> DISCHARGE <input type="checkbox"/> EYE PAIN <input type="checkbox"/> PHOTOPHOBIA <input type="checkbox"/> EYE REDNESS
EAR	<input type="checkbox"/> EAR PAIN <input type="checkbox"/> HEARING LOSS <input type="checkbox"/> RINGING IN EAR <input type="checkbox"/> DISCHARGE <input type="checkbox"/> HEARING AID
NOSE/MOUTH/THROAT	<input type="checkbox"/> SINUS CONGESTION <input type="checkbox"/> DYSPHAGIA <input type="checkbox"/> NOSE BLEED <input type="checkbox"/> INASAL DISCHARGE <input type="checkbox"/> DENTAL PAIN <input type="checkbox"/> HOARSENESS <input type="checkbox"/> SORE THROAT
BREAST	<input type="checkbox"/> N/A
HEME/LYMPH/ENDO	<input type="checkbox"/> HIV <input type="checkbox"/> BRUISING <input type="checkbox"/> IHX OF BLOOD TRANSFUSION <input type="checkbox"/> NIGHT SWEATS <input type="checkbox"/> SWOLLEN GLANDS <input type="checkbox"/> INCREASE THIRST <input type="checkbox"/> INCREASE HUNGER <input type="checkbox"/> COLD INTOLERANCE <input type="checkbox"/> HEAT INTOLERANCE <input type="checkbox"/> ABNORMAL BLEEDING
CARDIOVASCULAR	<input type="checkbox"/> CHEST PAIN <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> PND <input type="checkbox"/> ORTHOPNEA <input type="checkbox"/> EDEMA <input type="checkbox"/> SWEATING WITH FEEDING <input type="checkbox"/> EXERCISE INTOLERANCE
RESPIRATORY	<input type="checkbox"/> COUGH <input type="checkbox"/> WHEEZING <input type="checkbox"/> HEMOPTYSIS <input type="checkbox"/> DYSPNEA <input type="checkbox"/> PNEUMONIA HX <input type="checkbox"/> TB <input type="checkbox"/> ASTHMA HX <input type="checkbox"/> PRODUCTIVE SPUTUM <input type="checkbox"/> HOME OXYGEN @LPM.
GASTROINTESTINAL	<input type="checkbox"/> NAUSEA <input type="checkbox"/> VOMITING <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> HEPATITIS <input type="checkbox"/> HEMORRHOIDS <input type="checkbox"/> EATING DISORDER <input type="checkbox"/> ULCER <input type="checkbox"/> BLACK TARRY STOOL <input type="checkbox"/> ABDOMINAL PAIN <input type="checkbox"/> BLOOD IN STOOL <input type="checkbox"/> GERD <input type="checkbox"/> HEARTBURN
GENITOURINARY/NEPHROLOGY	<input type="checkbox"/> URGENCY <input type="checkbox"/> FREQUENCY <input type="checkbox"/> BURNING <input type="checkbox"/> DYSURIA <input type="checkbox"/> CHANGE IN COLOR OF URINE <input type="checkbox"/> INCONTINENCE <input type="checkbox"/> DISCHARGE <input type="checkbox"/> BLOOD IN URINE <input type="checkbox"/> PAINFUL/SWOLLEN GENITAL AREA
GYNECOLOGICAL	<input type="checkbox"/> N/A
LNMP	<input type="checkbox"/> LNMP
MUSCULOSKELETAL	<input type="checkbox"/> BACK PAIN <input type="checkbox"/> JOINT SWELLING <input type="checkbox"/> STIFFNESS <input type="checkbox"/> JOINT PAIN <input type="checkbox"/> FRACTURE HX <input type="checkbox"/> OSTEOPOROSIS <input type="checkbox"/> MUSCLE WEAKNESS <input type="checkbox"/> MYALGIA <input type="checkbox"/> FREQUENT FALLS <input type="checkbox"/> NECK PAIN <input type="checkbox"/> BACK PAIN
NEUROLOGICAL	<input type="checkbox"/> SYNCOP <input type="checkbox"/> SEIZURES <input type="checkbox"/> TRANSIENT PARALYSIS <input type="checkbox"/> WEAKNESS <input type="checkbox"/> PARESTHESIA <input type="checkbox"/> BLACK OUT SPELLS <input type="checkbox"/> SPONTANEOUS CHIANG <input type="checkbox"/> ICADACIC <input type="checkbox"/> TRICAMPS <input type="checkbox"/> DIFFICULTY/TROUBLE SWALLOWING
PSYCHIATRIC	<input type="checkbox"/> DEPRESSION <input type="checkbox"/> ANXIETY <input type="checkbox"/> NERVOUS <input type="checkbox"/> SLEEPING DIFFICULTY <input type="checkbox"/> SUBSTANCE ABUSE <input type="checkbox"/> SUICIDAL IDEATIONS/ATTEMPTS <input type="checkbox"/> PREVIOUS DX <input type="checkbox"/> INSOMNIA <input type="checkbox"/> HALLUCINATIONS <input type="checkbox"/> DISTURBED SLEEP

REVIEW OF SYSTEMS	
ENDOCRINE	<input type="checkbox"/> INCREASE THIRST <input type="checkbox"/> INCREASE URINATION <input type="checkbox"/> HIGH BLOOD SUGAR <input type="checkbox"/> LOW BLOOD SUGAR
ADDITIONAL COMMENTS :	

## PHQ-2

Little interest or pleasure in doing things in last 2 weeks  
 Feeling down, depressed, or hopeless in last 2 weeks  
 Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]

Select...  
 Select...  
 0

## Objective

## Objective Notes

## Assessment

## Assessment Notes

Diagnosis Codes	C.S.	Code	Description	Status	Diagnosed	Education	Cog.	Func.
	ICD10	N20.0	Calculus of kidney	ACTIVE	01/02/2026	No	No	No

## Procedure

## Procedure Notes

## Plan

## Plan Notes

Patient Referred Out and Summary of Care Provided: No  
 Clinical Summary Provided: No

Lab Orders	Rendering Provider	Test Codes	Order Status	Created Date
	DANIELLE OLSZESKI, PA	10231 - COMPREHENSIVE METABOLIC PANEL	ROUTINE	01/02/2026 09:21 AM CST

Recalls	Provider	Location	Reason	Recall Date
	ASHISH GUPTA, MD	BHMARFA	3 MONTH FOLLOW UP	02/11/2026

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**Patient Information:**

Patient:2yytest 2yytest      DOB: 01/02/1985      Sex: Female

Patient Address: 107 West Ave  
Valdosta GA 31605      Patient Phone: (555)-555-5555

Patient Diagnosis: ICD10: M25.561 - Pain in right knee; ICD10: R05.3 - Chronic cough

**Reason for Referral:**

evaluate and treat for please refer to urology for kidney stone (N20.0)

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