Appendix A. Primary Care Physician Task List During a Patient Encounter*

1. Enter room
2. Gather information from patient
2A. Chief complaint
2B. Problem information
2C. Patient's current medications
2D. Medications
2D(1). Side effects
2D(2). Medication instructions
2D(3). Compliance
2D(4). Effectiveness
2D(5). Evidence regarding medication treatment
2D(6). Reason for medication
2D(7). Refills needed
2D(8). Drug interactions
2D(9). Other
2E. Patient pharmacy
2F. Cost/access/insurance
2G. Allergies and adverse reactions
2H. Drug/alcohol use
2I. Tobacco use
2J. Exercise/diet
2K. Vitals/weight
2L. Daily life activities
2M. Support network, living situation, or help in emergency situation
2N. Advanced medical directive/end of life
2O. Family history
2P. Patient home monitoring information
2Q. Preventative screening
2R. Test results
2S. Physical exam
2T. Diagnosis
2U. Secondary patient
2V. Previous appointments with same doctor
2W. Review of symptoms/systems (not associated with main problems)
2W(1). Skin
2W(2). Neurological
2W(3). Gastrointestinal
2W(4). Constitutional (fever, weight loss, etc.)
2W(5). Eyes
2W(6). Ears, nose, mouth and throat
2W(7). Cardiovascular
2W(8). Respiratory
2W(9). Sleep
2W(10). Psychiatric
2W(11). Musculoskeletal/joints/feet
2W(12). Hematological
2W(13). Sexual/genital/urinary

2X. Social contact
2Y. "Anything else" question
2Z. Other
3. Review patient information
3A. Chief complaint
3B. Problem information
3C. Patient's current medications
3D. Medications
3E. Patient pharmacy
3F. Cost/access/insurance
3G. Allergies and adverse reactions
3H. Drug/alcohol use
3I. Tobacco use
3J. Exercise/diet
3K. Vitals/weight
3L. Daily life activities
3M. Support network, living situation, or help in emergency situation
3N. Advanced medical directive/end of life
3O. Family history
3P. Patient home monitoring information
3Q. Preventative screening
3R. Test results
3S. Physical exam
3T. Diagnosis
3U. Secondary patient
3V. Previous appointments with same doctor
3W. Nursing notes/clinic note
3X. Past medical/surgical history/problem list
3Y. Outside medical/counseling care
3Y(1). ER/urgent care
3Y(2). Specialist/other doctors
3Y(3). Hospitalizations
3Z. Follow-up appointment information
3AA. Patient paper forms
3BB. Other
4. Document patient information
4A. Chief complaint
4B. Problem information
4C. Patient's current medications
4D. Medications
4D(1). Side effects
4D(2). Medication instructions
4D(3). Compliance
4D(4). Effectiveness
4D(5). Evidence regarding medication treatment
4D(6). Reason for medication
4D(7). Refills needed
4D(8). Drug interactions
4D(9). Other

4E. Patient pharmacy
4F. Cost/access/insurance
4G. Allergies and adverse reactions
4H. Drug/alcohol use
4I. Tobacco use
4J. Exercise/diet
4K. Vitals/weight
4L. Daily life activities
4M. Support network, living situation, or help in emergency situation
4N. Advanced medical directive/end of life
4O. Family history
4P. Patient home monitoring information
4Q. Preventative screening
4R. Test results
4S. Physical exam
4T. Diagnosis
4U. Secondary patient
4V. Treatment plan
4W. Review of symptoms/systems (not associated with main problems)
4W(1). Skin
4W(2). Neurological
4W(3). Gastrointestinal
4W(4). Constitutional (fever, weight loss, etc.)
4W(5). Eyes
4W(6). Ears, nose, mouth and throat
4W(7). Cardiovascular
4W(8). Respiratory
4W(9). Sleep
4W(10). Psychiatric
4W(11). Musculoskeletal/joints/feet
4W(12). Hematological
4W(13). Sexual/genital/urinary
4X. Past medical/surgical history/problem list
4Y. Outside medical/counseling care
4Y(1). ER/urgent care
4Y(2). Specialist/other doctors
4Y(3). Hospitalizations
4Z. Follow-up appointment information
4AA. Other
5. Perform
5A. Procedure
5B. Vitals
5C. Physical exam
5D. Hand sanitization
5E. Immunization
5F. Fill out patient form
5G. Dictate
5H. Telephone call/answer phone/pager
5I. Calculation

5I(1). BMI
5I(2). Medication dosage
5J. Login to computer/EHR
5K. Open template
5L. Other
6. Recommend/discuss treatment options
6A. Medication
6B. Diet/exercise
6C. Test/preventive screening
6D. Procedure
6E. Follow-up appointment
6F. Referral to specialist
6G. Home remedy
6H. Non-traditional treatment
6I. Observation/wait and see/do nothing
6J. Immunization
6K. Home monitoring
6L. Get additional information
6M. Other
7. Look up
7A. Treatment information
7B. Referral doctor
7C. Drug information
7D. Other
8. Order
8A. Medication
8B. Test
8C. Referral to specialist
8D. Procedure
8E. Immunization
8F. Other
9. Communicate
9A. Nurse
9B. Other healthcare provider
10. Print/give patient (advice, instructions)
10A. Paper prescription
10B. Medication information/instructions
10C. Test order form
10D. Sample medication
10E. Disease/problem information
10F. Home monitoring card/paper
10G. Medical equipment
10H. Follow-up appointment information
10I. Appointment summary
10J. Referral information
10K. Other
11. Appointment wrap-up
11A. Walk patient
11A(1). Nurse station

11A(2). Waiting room
11A(3). Labs
11A(4). Radiology
11A(5). Reception
11B. Go to (appointment not over)
11B(1). Office
11B(2). Nurse station
11B(3). Waiting room
11B(4). Labs
11B(5). Radiology
11B(6). Reception
11B(7). Sample medication cabinet
11B(8). Another patient
11B(9). Other
11C. Log out of computer/EHR
12. Leave room