

The Family Medicine Prompt Pearls Manual

AI prompts mapped to clinical workflows, tasks & daily activities
Companion to the CTAFM 45-minute session · Izhar Hasan, MD, PhD

THE RULE BEHIND EVERY PROMPT IN THIS MANUAL
Copilot, not autopilot — AI organizes and drafts. You decide.

Risk Legend

GREEN — low risk, light review (drafting, organizing, nonclinical)

YELLOW — moderate risk, review before finalizing (patient-specific documentation)

ORANGE — high risk, verify closely (clinical reasoning, treatment-adjacent)

RED — do not delegate (final diagnosis, treatment, dosing) — no prompt provided

Quick Reference — Which Part Do I Need?

I	Prep for a visit	II	Handle an acute complaint
III	Manage a chronic condition	IV	Close a preventive care gap
V	Address women's health needs	VI	Address pediatric needs
VII	Address geriatric needs	VIII	Handle a behavioral health screen or referral
IX	Coordinate care with a specialist or hospital	X	Write or review a note
XI	Communicate with a patient	XII	Handle paperwork, forms, or admin
XIII	Make sense of a risk score	XIV	Handle musculoskeletal / sports medicine
XV	Handle a dermatologic complaint	XVI	Run a telehealth visit
XVII	Support gender-affirming or LGBTQ+ care	XVIII	Handle travel or occupational medicine
XIX	Manage substance use or chronic pain documentation		

PART I Pre-Visit & Chart Preparation

1 Pre-visit chart summary

YELLOW · review before finalizing

Summarize the last 12 months from this chart. Highlight clinical changes, medication changes, abnormal trends, preventive care gaps, and unresolved issues. Use only the facts present in the record. Organize as a short bulleted brief.

2 Multi-problem visit prioritization

YELLOW · review before finalizing

This patient has [list active problems] and a 20-minute visit. Organize these into: must-address today, can address if time allows, and can defer to a follow-up. Do not make treatment decisions — only help me sequence the visit.

3 Pre-visit lab/imaging gap check

YELLOW · review before finalizing

Based on this chart, list any guideline-recommended screening, labs, or imaging that appear due or overdue for this patient's age, sex, and documented conditions. Cite which guideline supports each. I will verify applicability before ordering anything.

4 New patient intake summary

YELLOW · review before finalizing

Organize this new-patient intake form and any transferred records into: active problem list, current medications, allergies, surgical history, and family history. Flag anything incomplete or contradictory across the documents so I can clarify directly with the patient.

PART II Acute Care Encounters

5 Symptom-based differential organization

ORANGE · verify closely

I am a family physician reviewing this de-identified presentation: [history, exam findings, vitals]. Organize a differential diagnosis by likelihood. For each, list supporting and opposing features and the single dangerous diagnosis I must not miss. Identify what finding would most change management. Use only what I've provided.

6 Red-flag / “don't miss” check

ORANGE · verify closely

Given this presentation: [symptoms], list the dangerous or emergent diagnoses that must be actively ruled out, and what specific history, exam finding, or test would help rule each in or out. Do not suggest a final diagnosis.

7 Return-precautions / safety-netting language

GREEN · light review

Draft return-precaution instructions for a patient being discharged home with [diagnosis/working diagnosis]. Sixth-grade reading level. Include specific symptoms that should prompt an ER visit versus a callback to the office.

8 Sore throat / URI workup organizer

ORANGE · verify closely

For a patient with [sore throat/URI symptoms and exam findings], organize the standard clinical decision points (e.g., Centor criteria) relevant to this presentation and what each favors. Do not recommend antibiotics or a final management plan — that decision is mine.

9 Low back pain red-flag screen

ORANGE · verify closely

Given this low back pain presentation: [history, exam], list the specific red-flag features (e.g., cauda equina, infection, malignancy signs) I should confirm are absent, and what finding would change urgency. Do not suggest imaging or treatment.

10 Minor laceration / wound follow-up plan draft

GREEN · light review

Draft home wound-care instructions and follow-up timing for a patient with [wound type/location/closure method]. Sixth-grade reading level. Include specific signs of infection that should prompt a call.

PART III Chronic Disease Management

11 Chronic disease visit summary with trend flags

YELLOW · review before finalizing

Summarize this patient's [diabetes/hypertension/CHF/COPD] control over the last 12 months. Show trend direction for key values (A1c, blood pressure, weight, etc.), flag any values outside goal range, and list medication changes during this period. Use only chart data provided.

12 Guideline-comparison for treatment options

ORANGE • review closely

For a patient with [condition] and [relevant comorbidities/contraindications], compare 2–3 guideline-recommended treatment options with trade-offs. Cite the specific guideline and year for each. Do not recommend a single best option — I will decide with the patient. I will verify every citation before use.

13 Medication reconciliation organizer

YELLOW • review before finalizing

Organize this medication list by indication, flag any that appear duplicated, discontinued elsewhere in the chart, or with a documented interaction. Do not recommend stopping or starting anything — only organize and flag for my review.

14 Polypharmacy / deprescribing discussion prep

ORANGE • review closely

This patient takes [medication list] and has [relevant history]. List medications that commonly warrant deprescribing review in similar patients per published criteria (e.g., Beers, STOPP/START), and why. I will make the final determination with the patient.

15 Asthma/COPD action plan draft

GREEN • light review

Draft a written action plan template (green/yellow/red zone format) for a patient with [asthma/COPD], using the specific medications and thresholds I provide here: []. Do not select medications or thresholds yourself — organize only what I specify.

16 Weight management visit summary

YELLOW • review before finalizing

Summarize this patient's weight, relevant labs, and documented attempts at management over time. Present as a trend, not a judgment. Flag any comorbidity that guideline sources typically link to weight-related risk, with citation, for my discussion with the patient.

PART IV Preventive Care & Screening

17 Age/sex-based preventive care gap list

GREEN • light review

Based on this patient's age, sex, and documented history, list preventive screenings and immunizations that are due per current guidelines. Cite the source for each recommendation. Flag anything ambiguous given comorbidities for my review.

18 Shared decision-making handout for a screening choice

GREEN • light review

Create a plain-language, balanced summary of benefits and risks of [screening test] for a patient with [relevant risk factors], to support a shared decision-making conversation. Sixth-grade reading level. Present both “for” and “against” fairly.

19 Population health outreach list organizer

GREEN • light review

Organize this list of patients with overdue [screening/immunization] into outreach priority groups based on how overdue they are and any documented barriers noted in the chart. This is for population outreach planning only, not individual clinical decisions.

20 Annual wellness visit agenda builder

GREEN • light review

Build an agenda for this patient's annual wellness visit based on age, documented history, and any items flagged since the last visit. Organize by: preventive items due, chronic disease check-ins needed, and any patient-reported concerns on file.

PART V Women's Health

21 Prenatal visit summary by trimester milestone

YELLOW • review before finalizing

Summarize this prenatal chart against the expected visit and screening schedule for [gestational age]. Flag any milestone screening that appears overdue or missing. Use only what's documented.

22 Contraception options comparison

ORANGE • review closely

For a patient with [relevant history/contraindications] interested in contraception, summarize appropriate options with effectiveness, common side effects, and any contraindications relevant to her history. I will discuss and decide with the patient; do not recommend one option as best.

23 Abnormal pap / follow-up tracking summary

YELLOW · review before finalizing

Summarize this patient's cervical screening history and results over time, and compare the recommended follow-up interval per current guidelines against what's actually scheduled. Flag any gap. Cite the guideline used.

24 Menopause symptom & options organizer

ORANGE · verify closely

For a patient reporting [menopausal symptoms] with history [], summarize common management categories (lifestyle, hormonal, non-hormonal) and general considerations for each, with guideline citations. Do not recommend a specific option — that's a shared decision with the patient.

PART VI Pediatric Care

25 Well-child visit milestone summary

YELLOW · review before finalizing

Summarize this child's growth trend and developmental milestones documented to date against expected norms for [age]. Flag any that appear delayed or undocumented. Use only chart data provided — do not infer.

26 Vaccine schedule reconciliation

YELLOW · review before finalizing

Compare this child's immunization record against the current recommended schedule for age [X]. List what's up to date, due, and overdue. Cite the schedule source. I will verify before administering anything.

27 Sports physical form drafting

GREEN · light review

Draft the narrative portions of a sports physical clearance form using the exam findings and history I provide here: []. Do not add any finding I haven't stated. Flag any standard clearance question I haven't addressed.

28 Parent guidance handout (common concern)

GREEN · light review

Draft a plain-language handout for parents about [common pediatric concern, e.g., fever management, feeding]. Sixth-grade reading level. Include specific criteria for when to call the office versus seek emergency care.

Note: pediatric medication and vaccine dosing calculations are RED — always calculate and verify independently; no prompt is provided for dosing.

PART VII Geriatric Care

29 Fall-risk and functional status summary

YELLOW · review before finalizing

Summarize documented fall history, mobility notes, and functional status changes over the last 12 months from this chart. Flag any pattern suggesting increasing risk. Use only what's documented.

30 Cognitive screening trend organizer

YELLOW · review before finalizing

Organize this patient's cognitive screening scores over time (e.g., MMSE, MoCA) into a simple trend view. Flag any decline pattern. Do not offer a diagnostic interpretation — that stays with clinical judgment.

31 Advance care planning conversation prep (informational only)

GREEN · light review

Draft plain-language, neutral educational material explaining what an advance directive and healthcare proxy are, for a general adult patient. Do not include any recommendation specific to this patient's prognosis or condition — this is general education only, to support a conversation I will lead.

32 Caregiver support resource summary

GREEN · light review

Draft a plain-language handout listing categories of caregiver support resources (respite care, support groups, financial assistance programs) relevant to [condition]. Do not name or recommend specific vendors or programs unless I provide them.

PART VIII Behavioral Health

33 Screening tool score organizer

YELLOW · review before finalizing

Organize these [PHQ-9/GAD-7/other] scores over time into a trend view and flag any score in a range that typically warrants clinical follow-up per the tool's standard scoring. Do not offer a diagnosis or treatment recommendation.

34 Warm handoff / referral summary for behavioral health

YELLOW · review before finalizing

Draft a referral summary for a behavioral health referral including: reason for referral, relevant history as documented, and current stressors as I specify here []. Use only what I've provided.

35 Substance use screening organizer

ORANGE · verify closely

Organize these substance-use screening results (e.g., AUDIT-C, DAST) over time into a trend view, flagging any score in a range that typically warrants further clinical assessment per the tool's standard scoring. Do not suggest a treatment plan or diagnosis.

Note: any prompt touching active suicidality, self-harm risk, or acute psychiatric crisis is RED — that assessment and response stays entirely with direct clinical judgment and your practice's crisis protocol, never AI drafting.

PART IX Care Coordination & Referrals

36 Specialist referral letter

YELLOW · review before finalizing

Draft a referral letter to [specialty] including: reason for referral, relevant history and findings I provide here [], current management, and my specific question for the consultant. Include only what I've stated.

37 Care transition summary (hospital-to-clinic)

YELLOW · review before finalizing

Summarize this discharge summary into: what changed during the admission, new medications and why, follow-up appointments needed, and outstanding issues for primary care to address. Flag anything unclear that I should confirm with the discharging team.

38 Specialist note reconciliation

YELLOW · review before finalizing

Compare this specialist's note against my current problem list and medication list. Flag any new recommendation, medication change, or follow-up requirement that isn't yet reflected in my records.

39 Home health / DME order summary

GREEN · light review

Draft the narrative justification for a home health or durable medical equipment order using the clinical need I specify here: []. Do not add any clinical justification I haven't stated.

40 Second-opinion prep packet

GREEN · light review

Organize this patient's relevant history, test results, and prior treatment attempts into a clean summary packet for a second-opinion consultation. Use only documented information; flag any gaps I should fill before sending.

PART X Documentation

41 Ambient visit note draft

YELLOW · review before finalizing

Draft a visit note from this encounter transcript, organized as [SOAP/your preferred format]. Include only what was said or observed — do not infer diagnoses or add clinical detail not present in the transcript.

42 Ambient note accuracy review

YELLOW · review before finalizing

Review this AI-generated note against the original transcript. Flag any statement that appears to be an inference rather than something explicitly said, and any clinical fact not clearly supported by the transcript. I will independently verify every flagged item before signing.

43 Visit note to after-visit summary

GREEN · light review

Convert this visit note into a patient-friendly after-visit summary at a sixth-grade reading level. Preserve all clinical facts exactly. Include follow-up instructions I specify here [].

44 Telehealth visit note draft

YELLOW • review before finalizing

Draft a telehealth visit note from this transcript, noting it was conducted via video/audio, documenting that consent and technical quality were confirmed, and including only what was discussed. Flag anything that would typically require an in-person exam that wasn't possible today.

PART XI Patient Communication**45 Portal message reply**

GREEN • light review

Draft a reply to this patient portal message: [paste]. Tone: warm, direct. Do not add clinical guidance beyond what I specify here: [your decision]. Keep under 150 words.

46 Complex explanation simplification

GREEN • light review

Rewrite this clinical explanation at a sixth-grade reading level: [paste]. Preserve every clinical fact exactly — do not add, remove, or soften meaning. End with three concrete next steps.

47 Multilingual patient handout draft

GREEN • light review

Translate this patient education handout into [language], preserving clinical accuracy. Flag any medical term that may not translate precisely so I can review with an interpreter or bilingual staff member.

48 No-show / recall outreach message

GREEN • light review

Draft a friendly outreach message for a patient who missed [appointment type] and is due for [reason]. Tone: non-judgmental, inviting. Keep under 100 words.

PART XII Administrative & Practice Operations**49 Prior authorization appeal letter**

GREEN • light review

Draft a prior authorization appeal for [medication/procedure] for a patient with [diagnosis, relevant history]. Reference the plan's stated denial reason: [reason]. Cite guidelines supporting medical necessity. One page. I will verify all claims before submitting.

50 Work/school note or disability form drafting

GREEN • light review

Draft a [work note / school note / disability form narrative] stating [restrictions/duration/reason] as I specify here. Use professional, neutral language. Do not add any clinical detail beyond what I provide.

51 Meeting or huddle summary

GREEN • light review

Summarize this meeting transcript into key decisions made, action items with owners, and open questions. Do not infer decisions that weren't explicitly stated.

52 Quality registry gap-closure planning

GREEN • light review

Organize this list of patients with open [HEDIS/quality measure] gaps by how close they are to falling out of the measurement window. This is for outreach planning only — not a clinical prioritization tool.

PART XIII Interpreting Predictive & Risk-Flag Tools**53 Predictive risk flag interpretation**

ORANGE • verify closely

This patient has an AI-generated [readmission/no-show/care-gap] risk flag of [level]. Explain in general terms what kind of data typically drives this type of flag. List what I should independently verify before acting on it. Do not suggest a specific clinical action.

54 Risk-score equity check

ORANGE • verify closely

Before relying on this risk score for [purpose], what are documented sources of bias or reduced accuracy for tools of this type across different patient populations? This is to inform my own scrutiny, not to validate the score.

PART XIV Musculoskeletal & Sports Medicine

55 MSK complaint history/exam organizer

ORANGE • verify closely

For this musculoskeletal complaint: [history, mechanism, exam findings], organize the relevant differential by structure involved (bone, ligament, tendon, joint) and what exam finding supports or argues against each. Do not suggest imaging or a final diagnosis.

56 Home exercise program handout draft

GREEN • light review

Draft a home exercise handout for [condition, e.g., mild lateral epicondylitis] using only the specific exercises I list here: []. Sixth-grade reading level with clear descriptions. Do not add exercises I haven't specified.

PART XV Dermatology

57 Lesion description organizer

ORANGE • verify closely

Organize this described skin lesion — [size, color, border, evolution, location] — using standard descriptive dermatologic terminology (e.g., ABCDE features) to support my own documentation and reasoning. Do not suggest a diagnosis.

58 Rash triage question set

ORANGE • verify closely

For a patient reporting [rash description], list the clarifying history and exam questions that would most help narrow the differential (e.g., distribution, timing, associated symptoms, exposures). Do not suggest a diagnosis or treatment.

PART XVI Telehealth-Specific Workflows

59 Telehealth visit suitability check

GREEN • light review

Given this reason for visit: [], list what aspects of the standard in-person workup for this complaint would be difficult or impossible over telehealth, so I can decide whether to convert this to an in-person visit.

60 Telehealth technical/consent documentation

GREEN • light review

Draft standard documentation language confirming telehealth modality, patient location, consent, and technology used, for me to append to today's note. Use only the details I specify here: [].

PART XVII Gender-Affirming & LGBTQ+ Care

61 Gender-affirming care informational handout

GREEN • light review

Draft a neutral, plain-language educational handout explaining [specific topic, e.g., a class of gender-affirming therapy] in general terms, without patient-specific recommendations. Sixth-grade reading level. I will personalize any clinical recommendation myself.

62 Inclusive intake language review

GREEN • light review

Review this patient intake form language for inclusivity regarding gender identity, sexual orientation, and family structure. Suggest neutral alternative phrasing where relevant. Do not change any clinical content.

PART XVIII Travel Medicine & Occupational Health

63 Travel medicine planning checklist

GREEN • light review

For a patient traveling to [destination] with [relevant health history], list the categories of travel-health preparation typically relevant (vaccines, prophylaxis, documentation) per current public health guidance, with citation. I will determine specific recommendations myself.

64 DOT / occupational physical form narrative

GREEN • light review

Draft the narrative portions of an occupational or DOT physical form using only the exam findings and history I provide here: []. Flag any standard certification question I haven't addressed.

PART XIX Substance Use & Chronic Pain Documentation

65 Controlled-substance agreement documentation organizer

GREEN • light review

Organize this patient's chronic pain management documentation — agreement dates, urine drug screen results on file, pill counts as recorded — into a compliance summary table. Do not interpret results or recommend continuing or discontinuing therapy.

66 Chronic pain functional-status trend summary

YELLOW • review before finalizing

Summarize this patient's documented functional status and pain scores over time into a trend view. Use only chart data provided. Do not recommend a treatment change.

Note: dosing decisions, tapering plans, and any determination of medication misuse are RED — those decisions stay entirely with direct clinical judgment, never AI drafting.

This manual provides templates, not clinical decisions. All AI output should be independently verified before clinical or administrative use, in line with your organization's approved tools and PHI policies. Prompts involving dosing, acute crisis management, or final diagnostic/treatment decisions are intentionally excluded — that judgment stays with you.