Your Hospital's Logo Here

HISTORY & PHYSICAL FORM

(for use by Resident Physician Staff)

PATIENT IDENTIFICATION

DATE:	TIME: (Military Time)

Source of Information:

Chief Complaint:

History of Present Illness:

Hospitalizations & Operations *(list chronologically)*

Year Diagnosis / Hospital

Past Medical History: PMD: _____ MD CALLED: ☐ YES ☐ NO

Family History:

PART OF THE MEDICAL RECORD

Current Medications, Dosages & Frequency:

Allergies *(Agent, Specific Reaction):*

Personal & Social History:

Occupation:	Birthplace:	Travel:
Marital Status / Children:	Diet:	Home Environment:
Smoking:	Alcohol:	
Drug Abuse:	Sexual History:	

Living Will / Advanced Directive / Power of Attorney for Medical Decision Making:

Vaccinations: ☐ Influenza: Date _____ ☐ Pneumovax: Date _____ ☐ Tetanus: Date _____

Pain History: Acute Pain ☐ Yes ☐ No Chronic Pain ☐ Yes ☐ No

(Include location; intensity [1-10 Pain Scale]; quality [Patient's own words]; onset; pattern; aggravating factors & alleviating factors)

System Review:

PHYSICAL EXAMINATION

(All positive & important negative findings must be recorded)

HEIGHT:	WEIGHT:	BMI:
RESP:	B / P:	
TEMP:	PULSE:	LMP:

PATIENT IDENTIFICATION

General:

Head:

Skin:

Eyes *(including fundi):*

ENT:

Neck *(nodes):*

Lung:

Lymphatic Exam:

Breast:

Heart:

Abdomen:

Spine:

Extremities:

Pulses	Carotid	Radial	Femoral	Popliteal	DP	PT
Right						
Left						
0 = Absent		1+ = Decreased		2+ = Normal		3+ = Hyperactive

Neurological:

Genitalia & Pelvic:

Rectal:

PART OF THE MEDICAL RECORD

Initial Laboratory Data *(including EKG, Chest X-Ray):*

Problem List & Differential Diagnosis:

Assessment & Plan

Please attach additional sheets to complete this portion comprehensively. Initial & date each additional sheet

CODE STATUS: _____

SOCIAL SERVICE NEEDS: _____

COUNSELING:

SMOKING / TOBACCO	☐ N/A	☐ YES
ALCOHOL	☐ N/A	☐ YES
DRUGS	☐ N/A	☐ YES

SIGNATURE / TITLE:	BEEPER:

PART OF THE MEDICAL RECORD