1. CHIEF COMPLAINT:
   REASON ADMITTED:

2. PRESENT ILLNESS:
   CO-EXISTING DIAGNOSIS:

3. PAST HISTORY:
   PRIOR TREATMENT

4. FAMILY HISTORY

5. MEDICATION REACTIONS: □ NO □ YES (If "YES", list):
6. KNOWN ALLERGIES: □ NO □ YES (If "YES", list):
7. CURRENT MEDICATIONS & DOSAGES:

8. SOCIAL HISTORY

9. PAIN HISTORY
   ACUTE PAIN □ NO □ YES
   CHRONIC PAIN □ NO □ YES
   (Include location; intensity [0-10 Pain Scale]; quality [Patient's own words]; onset; aggravating factors; alleviating factors)

10. VACCINATION HISTORY
    INFLUENZA: □ NO □ YES - Date ________
    PNEUMOVAX: □ NO □ YES - Date ________

11. SKIN
12. HEAD & ENT
13. EYES
14. METABOLIC
15. RESPIRATORY
16. CARDIAC
17. VASCULAR
18. G.I.
19. G.U.
20. GYN / C8
21. MUSCULOSKELETAL
22. NEUROLOGICAL
23. NEUROPSYCHIATRIC

(Use extra Progress Notes if necessary. Label "MEDICAL HISTORY" or "PHYSICAL EXAMINATION")

PART OF THE MEDICAL RECORD
### PHYSICAL EXAMINATION

**LMP:**  
**HT:**  
**WT:**  
**BMI:**  
**B/P:**  
**TEMP:**  
**PULSE:**  
**RESP:**

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1. **GENERAL APPEARANCE / FRAILTY:**

   DISTRESS ACUTENESS SEVERITY

2. **MENTAL STATUS / ALERT:**

   DEPENDANT / ANXIOUS

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3. **NECK / HEAD**

4. **E.E.N.T.**

5. **HEART**

6. **LUNGS**

7. **BREASTS**

8. **ABDOMEN**

9. **RECTAL**

10. **GENITALIA**

11. **MUSCULOSKELETAL**

12. **VASCULAR-PULSES**

13. **NEUROLOGICAL**

14. **SKIN**

15. **LYMPHATICS**

16. **LABORATORY**

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**NEG POS**

(Explain positive findings  Items may be identified by number)

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**INPATIENT ADMISSIONS ONLY**

**PROBLEM LIST**

**DIFFERENTIAL PLAN**

**MANAGEMENT PLAN**

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**TOBACCO / SMOKING**

**ETOH**

**DRUGS**

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**PRINT NAME:**  
**M.D.**

**SIGNATURE:**  
**M.D.**

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**PART OF THE MEDICAL RECORD**

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