Source of Information:

Chief Complaint:

History of Present Illness:

Hospitalizations & Operations *(list chronologically)*

<table>
<thead>
<tr>
<th>Year</th>
<th>Diagnosis / Hospital</th>
</tr>
</thead>
</table>

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

Family History:
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)

<table>
<thead>
<tr>
<th>HEIGHT:</th>
<th>WEIGHT:</th>
<th>BMI:</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESP:</td>
<td>B / P:</td>
<td></td>
</tr>
<tr>
<td>TEMP:</td>
<td>PULSE:</td>
<td>LMP:</td>
</tr>
</tbody>
</table>

General:

Head:

Skin:

Eyes (including fundi):

ENT:

Neck (nodes):

Lung:

Lymphatic Exam:

Breast:

Heart:

Abdomen:

Spine:

Extremities:

<table>
<thead>
<tr>
<th>Pulses</th>
<th>Carotid</th>
<th>Radial</th>
<th>Femoral</th>
<th>Popliteal</th>
<th>DP</th>
<th>PT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
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<tr>
<td>Left</td>
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</tbody>
</table>

0 = Absent  1+ = Decreased  2+ = Normal  3+ = Hyperactive

Neurological:

Genitalia & Pelvic:

Rectal:
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*

<table>
<thead>
<tr>
<th>CODE STATUS:</th>
<th>COUNSELING:</th>
<th>SMOKING / TOBACCO</th>
<th>ALCOHOL</th>
<th>DRUGS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ N/A</td>
<td>□ YES</td>
<td>□ N/A</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SOCIAL SERVICE NEEDS:</th>
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</table>

SIGNATURE / TITLE: 

BEEPER: 

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**PART OF THE MEDICAL RECORD**

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