

## HISTORY AND PHYSICAL

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

### Summary-Chief Complaint/History of Present Illness:

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### Past Medical History:

Medical Diagnosis:	Surgeries:	Medications:	Allergies:

### Social History:

Tobacco:  Yes  No    ETOH:  Yes  No    Married/Divorced/Widowed/Single    Lives with: \_\_\_\_\_

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### Review of Symptoms:

CONSTITUTIONAL	DERMATOLOGY	ENT	CARDIOLOGY	ENDOCRINE
Fever	Rash	Hearing Loss	Chest Pain	Polydipsia
Chills	Lumps	URI-S/S	Shortness of Breath	Polyuria
Weight Loss/Gain	Decubitus/Skin Issues	Sore Throat	Palpitations	Weight Changes
Loss of Appetite	Bruising	Vision Loss	Swelling	Fatigue
Pain Controlled				Blood Sugar ↑ or ↓
RESPIRATORY	GU	GI	PSYCHOLOGY	NEUROLOGY
SOB	Dysuria	Nausea/Vomiting	Depressed Mood	Memory Loss
DOE	Frequency	Diarrhea	Anxiety	Unsteady Gait
Cough	Pressure	Constipation	Sleep Problems	Visual Changes
Congestion	Incontinence	Abdominal Pain	Behaviors	Seizures
Wheezing	Blood in Urine			Headaches
				Speech Abnormality

## HISTORY AND PHYSICAL

<b>GENERAL:</b>	Well Developed/ Well Nourished	Overweight/Obese/Thin/Frail	Pleasant/Uncooperative/Agitated	Female/Male
<b>HEENT:</b>	Normal Canal/Auricle PERRL	Conjunctivae/Lids EOMI	Deviated Septum TM _____	Throat _____
<b>NECK:</b>	Symmetry	Mass/Adenopathy	Thyroid: NL/enlarged/mass	Carotid Bruit
<b>LUNGS:</b>	Clear to Auscultation	Wheeze	Rales	Rhonchi
			Diminished Breath Sounds	Effort: Easy/Mild Distress/Severe Distress
<b>HEART:</b>	Rate: NL/Bradycardia/Tachycardia	Rhythm: Sinus/Irregular/AFIB	Murmur: Yes/No	Click: Yes/No
<b>EXTREMETIES:</b>	Edema	Pulses: Radial _____	DP _____	PT _____
<b>ABDOMEN:</b>	BS: Normal/Increased/Decreased	Tenderness	Masses	Rebound Distended Scars
<b>SKIN:</b>	Warm	Moist	Rash	Lumps Incision Clean/Dry
			Well Approximated: Suture/Staples/Steri	
<b>NEURO:</b>	Alert/Lethargic/Non-responsive	Oriented: Person/Place/Time	Speech: NL/Slurred/Aphasic	Memory: Intact/Impaired
	Gait: NL/Unsteady/Non-ambulatory	Cranial Nerves: Intact	Motor: NL/Focal Deficit of _____	Sensation: Normal/Diminished _____
<b>ORTHO:</b>	Knee: _____	Shoulder: _____		
	Hip: _____	Elbow: _____		
	Foot/Ankle: _____	Wrist/Hand: _____		

**Other:**

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**IMPRESSION:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**PLAN:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Prognosis	Good/Fair/Poor
Rehab Potential	Good/Fair/Poor
Code Status	

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date