

HISTORY & PHYSICAL

Patient Name: _____ Date of Birth: _____ Sex: _____

Vital Signs: T _____ P _____ R _____ B/P _____ Height: _____ Weight: _____ (kg) _____ (lbs)

Allergies:

None ☐

Chief Complaint / History of Present Illness: _____

Medical History: _____

Surgical History: _____

Social History: _____

Family History: _____

Bleeding Disorders? No ☐ Yes ☐

Current Medication(s) (State dosage, frequency and route): _____

Physical Examination: Review of systems

N/A Normal Document Abnormalities:

Mental Status:			
Lungs:			
Heart:			
Integument/ Breast:			
HEENT:			
Neck/ Lymph:			
Abdomen:			
GU:			
Rectal/ Pelvic:			
Musculoskeletal:			
Neurological:			
Other Findings:			
Impression:			
Treatment Plan:			
Diagnostic Test Results			

Labs Attached? No ☐ Yes ☐ Patient cleared for surgery? No ☐ Yes ☐

M.D. Signature: _____ Date: _____