History And Physical Pre-Printed Form

Date:_____

Name_____ Age: _____ Sex: M / F

History Of Present Illness (Chief Complaint): _____

_____

_____

Allergies/Reactions:_____

Current Medications:_____

_____

History:

Medical/Surgical:_____

_____

Family:_____

Social: _____

Review Of Systems:_____

Physical Examination:

	Height:_____	Weight:_____	Temperature:_____
Vital Signs:	Blood Pressure:_____	Pulse:_____	Respirations:_____
Mental Status:			
Heent:			
Chest:			
Heart:			
Abdomen:			
Extremities:			
Other Pertinent Information			

Diagnosis:_____

_____

_____

Proposed Surgery/Procedure (Plan): _____

_____

Cleared For Surgery: ☐ Yes ☐ No

_____

Physician Signature Date Time

PATIENT LABEL