

HISTORY AND PHYSICAL EXAMINATION

Patient Name: _____ D.O.B.: _____ Date of Exam: _____

Chief Complaint (Patient's Own Words): _____

History of Present Illness: _____

Past Medical/Surgical History: _____

- No Recent Major Surgeries
- No Previous Surgery
- No Previous Hx. of Anesthesia Complications
- No Family Hx. of Anesthesia Complications

Personal Social History: _____

REVIEW OF SYSTEMS:

- + Heart - + Endocrine - Describe Any Positive Findings: _____
- + Lung - + Skin - _____
- + HEENT - + Extremities - _____
- + GI/GU - + Nuro - _____

ALLERGIES: NKDA Yes: _____

Medications: _____

Relevant Family History: _____

PHYSICAL EXAM: Vital Signs: BP: _____ HR: _____ RR: _____ Temp: _____ LMP: _____

- | | | | |
|--|--|--|--|
| General Appearance: No Distress or Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin: No Rashes, Lesions or Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eyes, Ears, Nose, Throat, Neck: Normal | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological: Grossly Intact, Oriented | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Respiratory: Bilaterally Clear | <input type="checkbox"/> Yes <input type="checkbox"/> No | Extremities: Pulses and Sensation Intact, No Edema | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abdomen: Soft, Non Tender | <input type="checkbox"/> Yes <input type="checkbox"/> No | Performed when appropriate to diagnosis: | |
| Cardiac: Regular Rhythm, No Significant Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Breast: Symetrical, No Lumps, No Discharge | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other: _____ | | Rectal: No Hemorrhoids, No Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Genital: No lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Describe Any Abnormalities: _____

Clinical Impression: _____

Plan: _____

ARNP/PA Signature: _____ Date: _____ Time: _____

Physician Signature: _____ Date: _____ Time: _____

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HPS JFKN-600-10002



Patient Identification/Label