History and Physical Form

Clinic / Hospital Information
Name:
Address:
Contact Number:
Physician / Examiner:
Date of Examination:
Time of Examination:

Patient Information
Name:
Age:
Gender: ◯ Female ◯ Male ◯ Other:
Date of Birth:
Patient ID:
Insurance Information:

Medical History
Chief Complaint:
History of Present Illness:
Past Medical History:
Surgical History:
Medications:
Allergies:
Family History:
Social History *(Tobacco use, alcohol consumption, drug use, occupation living situation):*
Review of Systems *(General health, recent weight changes, fever, etc.):*

Physical Examination

Vital Signs	
Blood Pressure:	/mmHg
Heart Rate:	/bpm
Respiratory Rate:	breaths/min
Temperature:	°F/°C
Oxygen Saturation:	%

General Appearance
Constitutional *(State of nutrition, apparent distress, etc.):*
Skin *(Color, moisture, lesions, wounds):*

HEENT (Head, Eyes, Ears, Nose, Throat)
Head *(Shape, symmetry):*
Eyes *(Pupillary response, visual acuity):*
Ears *(Hearing acuity, tympanic membrane appearance):*
Nose *(Patency, mucosa):*
Throat *(Oral mucosa, tonsils, pharynx):*

Neck
Thyroid *(Enlargement, nodules):*
Lymph Nodes *(Enlargement, tenderness):*

Cardiovascular
Heart Sounds *(Rate, rhythm, murmurs):*
Peripheral Pulses *(Presence, symmetry):*

Respiratory
Breath Sounds *(Clear, wheezes, crackles):*
Respiratory Effort *(Use of accessory muscles, retractions):*

Gastrointestinal
Abdomen *(Distention, tenderness, bowel sounds):*

Musculoskeletal
Extremities *(Deformities, range of motion, strength):*
Spine *(Alignment, tenderness):*

Neurological
Mental Status *(Orientation, speech, memory):*
Cranial Nerves *(Function):*
Motor *(Strength, tone):*
Sensory *(Touch, pain, vibration sense):*
Reflexes *(Deep tendon reflexes):*

Psychiatric
Mood and Affect:

Assessment and Plan
Preliminary Diagnosis:
Differential Diagnosis:
Plan: *(Further tests, consultations, treatment recommendations)*

Physician's Signature
Date:

Patient Consent

I, _____, consent to the proposed diagnostic and treatment plan.

Patient's Signature
Date: