

History and Physical Exam Form

Name: _____

Date: _____

ISN: _____

VS: BP:
Pulse:
Resp:
Temp:
Height:
Weight:

DOB: _____ AGE: _____

Gender: Male / Female

Complaint: Acute:
Chronic:

PMH: DM HTN STD TB
Hosp:
Surg:
Allergies:

Medications:

SocHx: Tobacco Y / N
PPDx _____ yrs
EtOH

ROS: HEENT:
CV:
PULM:
GI:
GU:
OB/GYN:
MS:
NEURO:
DERM:
ENDO:
PSYCH:

CXR: Normal / Abnormal
Findings:

PPD: Date placed: / /
Date read: / /
_____ mm

Immunizations: (given at this time)

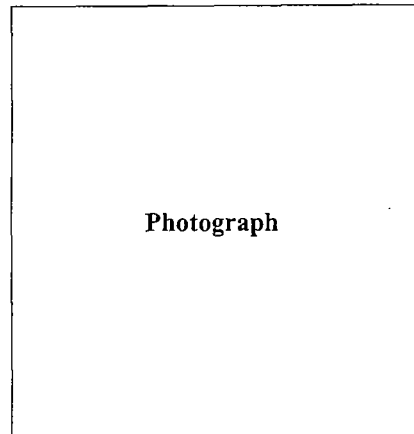
MMR Td Typhoid Polio

Influenza Meningococcal

Physical Exam:

HEENT: Normal / Abnormal
CV: Normal / Abnormal
PULM: Normal / Abnormal
GI: Normal / Abnormal
GU: Normal / Abnormal
OB/GYN: Normal / Abnormal / NA
MS: Normal / Abnormal
NEURO: Normal / Abnormal
DERM: Normal / Abnormal
ENDO: Normal / Abnormal
PSYCH: Normal / Abnormal

Comments / Findings:



Impression: _____

Plan: _____

Provider Signature:

Printed Name / Stamp:

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