Patient Label

Frederick Memorial Healthcare System
400 West 7th Street
Frederick, MD 21701
240-566-3300

History and Physical Exam

DATE: ________ NAME: ________________

AGE: ________ SEX: ________

CHIEF COMPLAINT: ________________

I. HISTORY OF PRESENT ILLNESS: ________________

ALLERGIES ________________

II. CURRENT MEDICATIONS & DOSAGES: ________________

III. PERTINENT SOCIAL AND FAMILY HISTORY:

IV. PAST HISTORY: (IF YES, EXPLAIN BELOW) ________________

V. ROS:

GENERAL ________

SKIN ________ GU ________

HEENT ________ NEURO/PSYCH ________

HEAD/NECK ________ MUSCULO ________

CARDIOVASCULAR ________ HEMATOLOGIC ________

RESPIRATORY ________

GI ________

VI. PHYSICAL EXAMINATION: (ABNORMAL FINDINGS AND PERTINENT NEGATIVES)

TEMP ______ **PULSE** ______ **RESPIRATIONS** ______ **BP** ______ **HEIGHT** ______ **WEIGHT** ______

_____ DENTURES _____ CONTACT LENSES _____ OTHER PROSTHESIS

H.E.E.N.T. ________________

HEART: ________ AIRWAY: ________

LUNGS: ________ BREAST: ________

ABDOMEN: ________ NEURO: ________

GENITALIA: ________ MENTAL STATUS: ________

EXTREMITIES: ________ SKIN: ________

VII. TENTATIVE DIAGNOSES: ________________

VIII. TREATMENT PLAN: ________________

I have examined the patient and reviewed the H&P and find it to be correct or have indicated changes.

SIGNATURE OF PROVIDER
COMPLETING H.P. ________________
DATE / TIME

IX. RISKS AND BENEFITS AND ALTERNATIVES TO PROCEDURE WERE DISCUSSED WITH THE PATIENT OR CONSENTING REPRESENTATIVE.

I have examined the patient and reviewed the H&P and find it to be correct or have indicated changes.

SIGNATURE OF PROVIDER
PERFORMING PROCEDURE ________________
DATE / TIME