History and Physical Form

EXAMINER AND CLINIC/HOSPITAL INFORMATION

Name: _____

Address:

Contact number: _____ Physician/examiner: _____

Date and time of examination: _____

Examiner's signature:

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Age: _____ Gender: _____

Patient ID: _____ Insurance's information: _____

Patient's signature:

MEDICAL INFORMATION

Chief complaint/presenting complaint:

History of chief/presenting complaint (symptoms and relevant risk factors):

Medical history:

Surgical history:

Medications (both prescribed and over the counter):

Allergies:

Family history:

Personal and social history (general well-being, alcohol/smoking/drug use, HIV risk factors, family relationships, etc.):

PHYSICAL INFORMATION

Vital signs

Blood pressure: _____ Heart rate: _____

Respiratory rate: _____ Temperature: _____

Oxygen saturation: _____ Other: _____

Please specify: _____

SYSTEMS REVIEW

General appearance

Skin:

HEENT:

Neck:

Cardiovascular

Respiratory

Gastrointestinal:

Musculoskeletal:

Genitourinary:

Neurological:

Central nervous system:

Endocrine:

Other: _____

Please specify:

ADDITIONAL NOTES

Specify below: