

Comprehensive History & Physical Exam

DEMOGRAPHICS

Providers Name: _____ Patient's Initials: (Data Source) _____

Date of Exam: _____ Patient's DOB/AGE: _____

Chief Complaint: _____ Gender/Sexual Orientation: _____

History of Present Illness:

Past Medical History:

Active Problems:

Resolved Problems:

Previous Hospitalizations:

Surgical History:

Allergies:

Current Medications:

Social History:

Living Arrangements:

Occupation:

Environmental Safety:

Smoking:

Alcohol:

Drugs:

Diet:

Other Non-Prescribed Drugs:

Family History:

Relationship	Living or Deceased	Age	Illnesses

Preventative Health/ Anticipatory Guidance: (Age Appropriate)

1. Safety Issues:
2. Screenings:
3. Immunizations:

Reproductive health:

Review of Systems:

General:

Skin, Hair, Nails:

HEENT:

Neck:

Cardiovascular:

Pulmonary:

Abd/GI:

Genitourinary/ Gynecology/ Breast:

Musculoskeletal:

Neuro:

Endo/Lymphatic:

Hematology:

Psych:

Physical Exam

Vital Signs: Temp: _____ Pulse: _____ BP: _____/_____ Resp: _____ O2 sat: _____

General:	
Head:	
Ears:	
Eyes:	
Nose:	
Throat:	
Neck:	

Assessment Statement:

Problem List (As many or as few as needed)

Include ICD - 10 CODE

1.

2.

3.

Plan:

1.

2.

3.

4.

Submitted by: _____

Date: _____