HISTORY & PHYSICAL EXAMINATION

ADVERSE REACTIONS (including latex & dyes)

PLEASE FOLD BACK OTHER PARTS BEFORE WRITING ON THIS SIDE

PATIENT IDENTIFICATION
(PLEASE PRINT)

CR #
NAME:

ADDRESS:

BIRTHDATE: (YYYY / MM / DD)
PHONE:

PLEASE COMPLETE ALL SECTIONS OF THIS FORM

HISTORY (RELEVANT MEDICAL/SURGICAL/FAMILY HISTORY)

SYSTEMS REVIEW

NO	YES		Details of "yes" answers or other
☐	☐	Diabetes	
☐	☐	Smoker	
☐	☐	Asthma / COPD / dyspnea	
☐	☐	Angina / Chest Pain / M.I.	
☐	☐	Edema / Orthopnea	
☐	☐	Hypertension	
☐	☐	Syncope / Seizures / TIA's	
☐	☐	Bleeding Problems	
☐	☐	G.I. Problems	
☐	☐	G.U. Problems	

MEDICATIONS (include prescription and over-the-counter medications)

PHYSICAL EXAMINATION

HT: cm WT: kg BP: HR: TEMP: °C

TICK IF NORMAL

- ☐ Head & Neck
- ☐ Chest
- ☐ CVS
- ☐ Abdomen
- ☐ Neuro / Extremities
- ☐ Genitourinary / Breast

IMPRESSION / SUMMARY

PRINTED NAME	PHYSICIAN'S SIGNATURE	DATE & TIME (YYYY / MM / DD HHMM)	OFFICE PHONE NUMBER