

HISTORY & PHYSICAL EXAMINATION

PATIENT IDENTIFICATION

(PLEASE PRINT)

CR #
NAME:

ADDRESS:

BIRTHDATE: (YYYY / MM / DD)

PHONE:

ADVERSE REACTIONS (including latex & dyes)

PLEASE FOLD BACK OTHER PARTS BEFORE WRITING ON THIS SIDE

PLEASE COMPLETE ALL SECTIONS OF THIS FORM.

HISTORY (RELEVANT MEDICAL/SURGICAL/FAMILY HISTORY)

SYSTEMS REVIEW

NO YES

- 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

Details of "yes" answers or other

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

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PHYSICAL EXAMINATION

HT: cm WT: kg BP: HR: TEMP: °C

TICK IF NORMAL

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

IMPRESSION / SUMMARY

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