

Patient Name: _____ Chief Complaint: _____

History of Present Illness: _____

PAST HISTORY	DESCRIPTION OF FINDINGS					
Medical						
Surgical						
Allergies						
Medications						
Psycho/Social						
Smoking/Alcohol						
Family						
SYSTEMS REVIEW	<input type="checkbox"/> Negative <input type="checkbox"/> Negative except:					
PHYSICAL EXAM	HT:	WT:	T:	P:	R:	BP:
Appearance						
EENT	WNL: <input type="checkbox"/> YES <input type="checkbox"/> NO					
Neck	WNL: <input type="checkbox"/> YES <input type="checkbox"/> NO					
Cardiovascular	WNL: <input type="checkbox"/> YES <input type="checkbox"/> NO					
Chest	WNL: <input type="checkbox"/> YES <input type="checkbox"/> NO					
Respiratory	WNL: <input type="checkbox"/> YES <input type="checkbox"/> NO					
Neurological	WNL: <input type="checkbox"/> YES <input type="checkbox"/> NO					
GI (Abdomen) <input type="checkbox"/> NE	WNL: <input type="checkbox"/> YES <input type="checkbox"/> NO					
Genitourinary <input type="checkbox"/> NE	WNL: <input type="checkbox"/> YES <input type="checkbox"/> NO					
Lymphatic <input type="checkbox"/> NE	WNL: <input type="checkbox"/> YES <input type="checkbox"/> NO					
Musculoskeletal <input type="checkbox"/> NE	WNL: <input type="checkbox"/> YES <input type="checkbox"/> NO					
Skin <input type="checkbox"/> NE	WNL: <input type="checkbox"/> YES <input type="checkbox"/> NO					

*NE = Not Examined

RESULTS of RELEVANT DIAGNOSTIC STUDIES: (Required for operative or invasive procedures.)

IMPRESSION: _____

PLAN: _____

DATE: _____ TIME: _____ MD SIGNATURE: X _____

PROGRESS NOTE NOTE: H & P's UP TO 30 DAYS OLD ARE ACCEPTED. WHEN OLDER THAN 24 HOURS, AN UPDATE IS REQUIRED PRIOR TO THE PROCEDURE.

No significant changes since the above was recorded. Other: _____

DATE: _____ TIME: _____ MD SIGNATURE: X _____

BAYLOR MEDICAL CENTER AT FRISCO

History and Physical