

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**