

History And Physical Pre-Printed Form

Date: _____

Name _____ Age: _____ Sex: M / F

History Of Present Illness (Chief Complaint): _____

Allergies/Reactions: _____

Current Medications: _____

History:

Medical/Surgical: _____

Family: _____

Social: _____

Review Of Systems: _____

Physical Examination:

	Height: _____	Weight: _____	Temperature: _____
Vital Signs:	Blood Pressure: _____	Pulse: _____	Respirations: _____
Mental Status:			
Heent:			
Chest:			
Heart:			
Abdomen:			
Extremities:			
Other Pertinent Information			

Diagnosis: _____

Proposed Surgery/Procedure (Plan): _____

Cleared For Surgery: Yes No

Physician Signature

Date

Time

HCA Florida Palms West Hospital
Loxahatchee, FL

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PATIENT LABEL