

HISTORY & PHYSICAL EXAMINATION



Date of Admission: _____

TMH1367

History obtained from: Patient Family/Friend Chart record Unable to obtain (Reason): _____

Chief Complaint/Present Illness/Reason for Admission: _____

History of Present Illness: _____

Past Medical History: _____

Past Surgical History: None _____

Family History: None _____

Social History: Tobacco _____ Alcohol _____ Illicit Drugs _____ Other _____

Allergies: No Known Drug Allergies or _____

Medications: None or _____

Review of Systems: (Check if negative, Describe if abnormal)

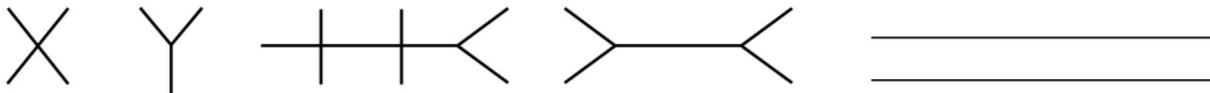
<input type="checkbox"/> Constitutional (ex. weight loss, fever, etc.)	<input type="checkbox"/> Cardiovascular
<input type="checkbox"/> Eyes	<input type="checkbox"/> Gastrointestinal
<input type="checkbox"/> Ears, Nose, and Throat	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Neurologic
<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Endocrine
<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Allergic/Immunological
<input type="checkbox"/> Integumentary (skin and breast)	<input type="checkbox"/> Hematologic/Lymphatic



Physical Exam:

<input checked="" type="checkbox"/> Normal Exam Findings		Describe Abnormal Exam Findings
Vital Signs	T _____ BP _____ P _____ R _____ Wt _____ Ht _____ O2Sat _____ % Pain _____ /10	
EENT	<input type="checkbox"/> Extraocular Muscles Intact <input type="checkbox"/> Sclera Anicteric <input type="checkbox"/> Pupils Equal, Round, Reactive to Light <input type="checkbox"/> Oropharynx Clear <input type="checkbox"/> Mucous Membranes Moist	
Neck/ Back	<input type="checkbox"/> Supple <input type="checkbox"/> No Thyromegaly <input type="checkbox"/> No Costovertebral Angle Tenderness	
Breast	<input type="checkbox"/> No Masses <input type="checkbox"/> No Nipple Discharge	
Chest	<input type="checkbox"/> Clear Auscultation <input type="checkbox"/> Clear Percussion <input type="checkbox"/> Normal symmetry & Expansion	
Cardiac	<input type="checkbox"/> Regular Rhythm & Rate <input type="checkbox"/> No Jugular Venous Distention <input type="checkbox"/> No Murmurs/Rubs/Gallops	
Abdomen	<input type="checkbox"/> Soft <input type="checkbox"/> Normal Bowel Sounds <input type="checkbox"/> Nontender <input type="checkbox"/> No Organomegaly <input type="checkbox"/> No Masses Palpable	
Extremities	<input type="checkbox"/> Normal Range of Motion & Stability <input type="checkbox"/> Normal Muscle Strength & Tone <input type="checkbox"/> No Edema, Clubbing or Cyanosis	
Nodes	<input type="checkbox"/> No Cervical Adenopathy <input type="checkbox"/> No Axillary Adenopathy <input type="checkbox"/> No Inguinal Adenopathy	
Skin	<input type="checkbox"/> No rash, ulcerations, breakdown <input type="checkbox"/> Warm <input type="checkbox"/> Dry <input type="checkbox"/> Clear	
GU/ Rectal	<input type="checkbox"/> Normal Tone <input type="checkbox"/> No Hemorrhoid(s)/Fissure <u>Male:</u> <input type="checkbox"/> Normal External Genitalia <input type="checkbox"/> Normal Prostate Exam <u>Female:</u> <input type="checkbox"/> Normal External Genitalia <input type="checkbox"/> Normal Pelvic Exam	
Neuro	<input type="checkbox"/> Alert & Oriented X3 <input type="checkbox"/> Cranial Nerves Intact <input type="checkbox"/> Sensation Intact <input type="checkbox"/> Motor Exam Nonfocal	
Psych	<input type="checkbox"/> Normal Judgment & Insight <input type="checkbox"/> Normal Mood & Affect <input type="checkbox"/> Oriented to time, place, person	

Lab(s):



Diagnostic(s): _____

Assessment and Plan: _____

/ _____
Date Time Resident Signature

I have seen and examined the patient and discussed with
Dr. _____, Resident/Fellow. I agree with the resident's
findings and plan as documented in the resident's note with any noted exception.

I was present with resident during the history and exam. I discussed the
case with the resident and agree with the findings and plan as documented
in the resident's note with any noted exception.

/ _____
Date Time Physician Signature

