

INPATIENT ADMITTING HISTORY AND PHYSICAL

Date of Service / / PROVIDER COMMENTS--REVIEW OF SYSTEMS, continued

PAST MEDICAL, FAMILY, AND SOCIAL HISTORY

Allergies: (agent, specify reaction) _____

Past Medical History, continued [*Childhood Illnesses, Past Hospitalizations and Operations, Immunizations, Medications, Past Illnesses, Past Injuries, Transfusions, Traumas (i.e., S/P CABG 1999; Hx of Pneumonia 2004)*]

	MEDICATIONS (prescription, O-T-C, vitamins, herbals)	DOSAGE PER DAY	LAST DOSE (Date and Time)	DATE STARTED
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Family History (Document diseases related to the Chief Complaint(s), History of Present Illnesses, or Review of Systems, Hereditary or High Risk Diseases for the patient's parents, siblings and/or children) _____

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Date of Service / /	PAST MEDICAL, FAMILY AND SOCIAL HISTORY, continued
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Social History (Alcohol Use, Educational History, Employment History, High Risk Behavior, Illicit Drug Use, Living Arrangements, Marital Status, Sexual Activity/Contraceptive Use, Tobacco Use, Travel History) _____

DID MEDICAL STUDENT DOCUMENT REVIEW OF SYSTEMS AND PAST MEDICAL, FAMILY, AND SOCIAL HISTORY?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
IF YES, MEDICAL STUDENT'S SIGNATURE (include credentials, i.e., M.S. III)	↓ DATE ↓	↓ TIME ↓	<input type="checkbox"/> AM <input type="checkbox"/> PM

PHYSICAL EXAMINATION

Constitutional: Vital Signs	Temperature	Blood Pressure	Respiratory Rate	Pulse	Height	Weight	Constitutional: Vital Signs
		Normal	Abnormal	DOCUMENT ABNORMAL AND/OR PERTINENT FINDINGS IN DETAIL			
Constitutional, continued							
General appearance of patient (development, nutrition body habitus, deformities, attention to grooming)	<input type="checkbox"/>	<input type="checkbox"/>					
Eyes							
Conjunctivae and Lids	<input type="checkbox"/>	<input type="checkbox"/>					
Pupils and Irises	<input type="checkbox"/>	<input type="checkbox"/>					
Ears, Nose, Mouth and Throat							
Otoscopic Examination	<input type="checkbox"/>	<input type="checkbox"/>					
Hearing Assessment	<input type="checkbox"/>	<input type="checkbox"/>					
Inspection of Nasal Mucosa, Septum, and Turbinates	<input type="checkbox"/>	<input type="checkbox"/>					
Inspection of Lips, Teeth and Gums	<input type="checkbox"/>	<input type="checkbox"/>					
Examination of Oropharynx	<input type="checkbox"/>	<input type="checkbox"/>					
Neck							
Examination of Neck	<input type="checkbox"/>	<input type="checkbox"/>					
Examination of Thyroid	<input type="checkbox"/>	<input type="checkbox"/>					

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	Normal	Abnormal	DOCUMENT ABNORMAL AND/OR PERTINENT FINDINGS IN DETAIL
Respiratory			
Assessment of respiratory effort	<input type="checkbox"/>	<input type="checkbox"/>	
Percussion of Chest	<input type="checkbox"/>	<input type="checkbox"/>	
Palpation of Chest	<input type="checkbox"/>	<input type="checkbox"/>	
Auscultation of Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular			
Auscultation of heart	<input type="checkbox"/>	<input type="checkbox"/>	
Palpation of Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of Abdominal Aorta	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of Carotid arteries	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of Femoral Arteries	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of jugular veins (distension, a, v or cannon a waves)	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of Pedal Pulses	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of Extremities for Edema and/or varicosities	<input type="checkbox"/>	<input type="checkbox"/>	
Chest			
Inspection of Breasts	<input type="checkbox"/>	<input type="checkbox"/>	
Palpation of Breasts and Axillae	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal			
Abdominal exam--masses/tenderness	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of Liver and Spleen	<input type="checkbox"/>	<input type="checkbox"/>	
Examination for Hernia	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of anus/perineum/rectum	<input type="checkbox"/>	<input type="checkbox"/>	
Occult blood test (when indicated)	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary (FEMALE)			
Pelvic Examination, including:			
Examination of External Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of Urethra (masses, tenderness, scarring)	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of Bladder (fullness, masses, tenderness)	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of Cervix	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of Uterus	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of Adnexa/Parametria	<input type="checkbox"/>	<input type="checkbox"/>	

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Date of Service / /			PHYSICAL EXAMINATION, continued
Genitourinary (MALE)	Normal	Abnormal	DOCUMENT ABNORMAL AND/OR PERTINENT FINDINGS IN DETAIL
Examination of Scrotal Contents	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of Penis	<input type="checkbox"/>	<input type="checkbox"/>	
Digital Examination of Prostate	<input type="checkbox"/>	<input type="checkbox"/>	
Lymphatic--Palpation of Lymph Nodes in:			
Neck	<input type="checkbox"/>	<input type="checkbox"/>	
Axillae	<input type="checkbox"/>	<input type="checkbox"/>	
Groin	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify in documentation →)	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal			
Exam of gait/station	<input type="checkbox"/>	<input type="checkbox"/>	
Inspection/palpation of digits/nails	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of joints/bones/muscles:			
Head and neck	<input type="checkbox"/>	<input type="checkbox"/>	
Spine, ribs, and pelvis	<input type="checkbox"/>	<input type="checkbox"/>	
Right Upper Extremities (RUE)	<input type="checkbox"/>	<input type="checkbox"/>	
Left Upper Extremities (LUE)	<input type="checkbox"/>	<input type="checkbox"/>	
Right Lower Extremities (RLE)	<input type="checkbox"/>	<input type="checkbox"/>	
Left Lower Extremities (LLE)	<input type="checkbox"/>	<input type="checkbox"/>	
Skin			
Inspection of Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Subcutaneous Tissue	<input type="checkbox"/>	<input type="checkbox"/>	
Palpation of Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Subcutaneous Tissue	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic			
State of consciousness for mental status examination (GSC score)	<input type="checkbox"/>	<input type="checkbox"/>	
Test Cranial Nerves	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of	<input type="checkbox"/>	<input type="checkbox"/>	
Deep Tendon Reflexes			
Examination of gait and station	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of motor system	<input type="checkbox"/>	<input type="checkbox"/>	
Examination of Sensation	<input type="checkbox"/>	<input type="checkbox"/>	
Test Coordination (finger/nose, heel/knee/shin, rapid alternating movements in upper/lower extremities)	<input type="checkbox"/>	<input type="checkbox"/>	

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Date of Service / /			PHYSICAL EXAMINATION, continued
Psychiatric	Normal	Abnormal	DOCUMENT ABNORMAL AND/OR PERTINENT FINDINGS IN DETAIL
Judgment/Insight	<input type="checkbox"/>	<input type="checkbox"/>	
Orientation to Time, Place, and Person	<input type="checkbox"/>	<input type="checkbox"/>	
Recent and Remote Memory	<input type="checkbox"/>	<input type="checkbox"/>	
Mood and Affect	<input type="checkbox"/>	<input type="checkbox"/>	

(REMINDER: Physicians have the option of performing a single organ system exam *in addition to* or *in lieu of* the general multi-system exam.)

Multiple horizontal lines for detailed notes.

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Date of Service / / Medical Decision Making/Assessment/Plan

Assessment/Diagnoses:

Plan (MUST include documentation of pain management!):

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