



HISTORY AND PHYSICAL

Patient Name: _____ DOB: _____

Informant: _____ Relationship _____

Date ___/___/___ Time: _____ hours/minutes

Primary Care Physician: _____ Referring Hospital/Physician: _____

Chief Complaint: _____

History of Present Illness: _____

Past Medical/Surgical History: _____

REVIEW OF SYSTEMS

	See HPI	Negative
HEENT: _____	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary: _____	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular: _____	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal: _____	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary/Reproductive: LMP ___/___/_____ Premenarchal	<input type="checkbox"/>	<input type="checkbox"/>
Bone/Skin/Joint: _____	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic: _____	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine: _____	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric: _____	<input type="checkbox"/>	<input type="checkbox"/>
Smoking/Drugs/Alcohol Use/Abuse: _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergies: NKA <input type="checkbox"/>		
Food allergies/ reaction: _____		

Patient Name: _____ DOB: _____

Food allergies/ reaction: _____

Medication allergies/ reaction: _____

Medication allergies/reaction: _____

Medications/Herbal Preparations/Dietary Supplements: _____

PHYSICAL EXAM

Wt: _____ kg Ht: _____ in Birth Weight: _____ T: _____ °F P: _____ R: _____ BP: ____/____

General: _____

HEENT: _____ Tonsils: _____

Neck/Lymphatics: _____

Gastrointestinal: _____

Respiratory: _____

Cardiovascular/Pulses: _____

Extremities: _____

Skin: _____

Neurological: _____

Other: _____

Laboratory/Radiology/Ancillary Results: _____

Assessment/Plan: _____

Child cleared for in office IV sedation YES _____ NO _____

Provider Signature/Title: _____ Date: _____

Provider Printed Name: _____

Practice Location: _____

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