



NAME	
DOB	
MR NO.	

PHYSICIAN'S HISTORY | PHYSICAL EXAMINATION

SOCIO-ECONOMIC

INCLUDE HABITS (e.g. smoking, etc.)

FAMILY HISTORY

REVIEW OF SYSTEM *If a box is ticked, provide explanation

RESPIRATORY

- | | |
|---|--|
| <input type="checkbox"/> Within normal limits (WNL) | <input type="checkbox"/> Dyspnea |
| <input type="checkbox"/> COPD or asthma | <input type="checkbox"/> Hemoptysis |
| <input type="checkbox"/> Cyanosis | <input type="checkbox"/> O ₂ Theray |
| <input type="checkbox"/> Cough | |
| <input type="checkbox"/> Sputum | |
| <input type="checkbox"/> Pleuritic pain | |

EXPLAIN

GASTROINTESTINAL

- | | |
|---|---|
| <input type="checkbox"/> Within normal limits (WNL) Appetite: _____ | |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Hematemesis | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Change of bowel habits | |

EXPLAIN

MUSCULOSKELETAL

- | | |
|---|--|
| <input type="checkbox"/> Within normal limits (WNL) | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Joint or bone pain | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Range of motion |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Miopathy |

EXPLAIN

CARDIOVASCULAR

- | | |
|--|--|
| <input type="checkbox"/> Within normal limits (WNL) | <input type="checkbox"/> Chest pain or tightness |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Syncope |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Paroxysmal nocturnal dyspnea | <input type="checkbox"/> Atypical pain |
| <input type="checkbox"/> Exertional dyspnea or orthopnea | <input type="checkbox"/> Varicous Veins |

EXPLAIN

REPRODUCTIVE

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Within normal limits (WNL) | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Birth control | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Bleeding | Para: _____ |
| <input type="checkbox"/> Discharge | Gravida: _____ |
| <input type="checkbox"/> Obstetric history | <input type="checkbox"/> LMP: _____ |
| <input type="checkbox"/> Menstrual history | |

EXPLAIN

NEUROLOGICAL

- | | |
|---|--|
| <input type="checkbox"/> Within normal limits (WNL) | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Weakness or paralysis |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Fall |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Gait _____ |
| <input type="checkbox"/> Slurred disturbance | <input type="checkbox"/> Aphasic |
| <input type="checkbox"/> Visual disturbance | <input type="checkbox"/> Seizures |

EXPLAIN

GENITOURINARY

- | | |
|---|------------------------------------|
| <input type="checkbox"/> Within normal limits (WNL) | <input type="checkbox"/> Frequency |
| <input type="checkbox"/> Urgency | <input type="checkbox"/> Dysuria |
| <input type="checkbox"/> Nocturia | <input type="checkbox"/> Catheter |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Polyuria |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Oliguria |
| <input type="checkbox"/> Hematuria | <input type="checkbox"/> Pyuria |
| <input type="checkbox"/> Pain over Kidneys | |

EXPLAIN

HEMATOLOGY

- | | |
|---|---|
| <input type="checkbox"/> Within normal limits (WNL) | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bruising or bleeding |
| <input type="checkbox"/> Enlarged lymph nodes | |

EXPLAIN

INTEGUMENTARY (SKIN)

- | | |
|---|--|
| <input type="checkbox"/> Within normal limits (WNL) | <input type="checkbox"/> Poor or slow healing |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Unusual lesions or pigmentation changes |
| <input type="checkbox"/> Pruritus | |
| <input type="checkbox"/> Dry | |
| <input type="checkbox"/> Hair | |
| <input type="checkbox"/> Nails | |

EXPLAIN

ENDOCRINE

- | | |
|---|--|
| <input type="checkbox"/> Within normal limits (WNL) | |
| <input type="checkbox"/> Polyphagia | |
| <input type="checkbox"/> Temperature sensitivity | |
| <input type="checkbox"/> Fever | |
| <input type="checkbox"/> Night sweats | |
| <input type="checkbox"/> Weight changes | |

EXPLAIN