

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS: _____

PAST HISTORY: Medical

Surgical: _____

Allergies: _____

Social / Family History: _____

Medications: None

SYSTEMS REVIEW: Negative Negative except:

Physical Exam:	Vital Signs:	Pediatrics:	Vital Signs Reviewed: <input type="checkbox"/>
	P:	Length/Height:	
	R:	Weight:	
	BP:	Head Circumference: cm	
	Temp:	Immunization Status::	

EENT: WNL: Yes

Cardiovascular: WNL: Yes

Resp / Chest: WNL: Yes

GI (abdomen): WNL: Yes

Genitourinary: NA*: WNL: Yes

Hemo / Lymphatic: WNL: Yes

Musculoskeletal: WNL: Yes

Skin: WNL: Yes

Neuro / Psych: WNL: Yes

RESULTS OF RELEVANT DIAGNOSTIC STUDIES: None

IMPRESSION:

PLAN:

H&P COMPLETED BY: _____ **DATE:** _____ **TIME:** _____
 (Only required if not completed by an MD / DO)

Date: _____ Time: _____ Signature: **X**

NOTE: H&P's less than 30 DAYS old may be used if reassessment is documented on the H&P within the last 24 HOURS.

Interval Note: No significant change since the H&P of _____ (date) was recorded.

Other:

Date: _____ Time: _____ Signature: **X**



The Medical Center of Plano

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Outpatient History and Physical



HPS

PATIENT IDENTIFICATION