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CLINICAL HISTORY AND PHYSICAL EXAMINATION

FAX RESULTS TO: 513-671-0135

Hospital: ______________________________

Patient Name: ______________________________

Date of Birth: ____________________ Date to be Admitted: ____________________

Reason for Admission/Procedure: ______________________________

____

History of Present Illness: ______________________________

____

Drug or Other Significant Allergies: ______________________________

Past History (Family/Social History): ______________________________

____

Smoking HX: ______________________________

Diabetes: ☐ Yes ☐ No HX of Steroid TX: ☐ Yes ☐ No Bleeding Tendency: ☐ Yes ☐ No

Current Medications (including ASA): ______________________________

____

ALL "YES" ANSWERS REQUIRE AMPLIFICATION

R.O.S.: Pain or Discomfort ☐ Yes ☐ No Specify ______________________________

Cardiovascular: Chest Pain ☐ Yes ☐ No
Syncope ☐ Yes ☐ No
HX of MI ☐ Yes ☐ No
Other Pertinent Symptoms ☐ Yes ☐ No

Respiratory: Effort Tolerance ☐ Yes ☐ No
HX of Asthma ☐ Yes ☐ No
Cough ☐ Yes ☐ No
Other Pertinent Symptoms ☐ Yes ☐ No

Neurological: HX of Transient Neurological Symptoms ☐ Yes ☐ No
Other Pertinent Symptoms ☐ Yes ☐ No

Gastrointestinal: Abdominal Pain ☐ Yes ☐ No
HX of Hepatitis ☐ Yes ☐ No
Nausea ☐ Yes ☐ No
Other Pertinent Symptoms ☐ Yes ☐ No

Reproductive: LMP Date ____________________

Continued on Other Side

Continued from Other Side

PHYSICAL EXAMINATION:

Patient Name: ______________________________

General Appearance: ______________________________

BP: ____________ PR: ____________ RESP: ____________ TEMP: ____________

HEENT: ______________________________

Neck: ______________________________ Bruits: ☐ Yes ☐ No

Chest & Lungs: ______________________________

Breast: ______________________________

Heart: ______________________________ Murmur: ☐ Yes ☐ No

Abdomen: ______________________________

Pelvic/Rectal Inguino-Genital: ______________________________

Extremities: ______________________________ Venous Stasis: ☐ Yes ☐ No

Neurological: ______________________________

Assessment: ______________________________

IS PATIENT CLEARED FOR SURGERY: ☐ YES ☐ NO

What Lab was used for Bloodwork? ______________________________

Lab Phone: ______________________________

Signature: ______________________________ Date of Examination: ____________

Name Printed: ______________________________ Phone#: ____________

PLEASE KEEP A COPY OF THE H&P FORM FOR YOUR RECORDS

Thank You