|  |  |
| --- | --- |
| **History and Physical Exam** | Date |
| **Patient Name** | **Date of Birth** |
|  |
| **HISTORY:** |
| [ ]  Review of Health Questionnaire Dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **ALLERGIES:** |
|   |
| Health issues requiring treatment or continued care:  |
|   |
|  |
| **PHYSICAL EXAM:** |
| **Vital signs:** | Height |  | Weight |  | BMI |  |
| BP |  | Pulse |  | Resp Rate |  | Temp |  |
|  | **Findings** | **Describe abnormal findings**  |
| **Constitutional:** | **[ ] Normal** | **[ ] Abnormal** |  |
|  |
| **Head:** | **[ ] Normal** | **[ ] Abnormal** |  |
|  |
| **EENT:** | **[ ] Normal** | **[ ] Abnormal** |  |
|  |
| **Neck:** | **[ ] Normal** | **[ ] Abnormal** |  |
|  |
| **Respiratory:** | **[ ] Normal** | **[ ] Abnormal** |  |
|  |
| **Cardiovascular:** | **[ ] Normal** | **[ ] Abnormal** |  |
|  |
| **Gastrointestinal:** | **[ ] Normal** | **[ ] Abnormal** |  |
|  |
| **Lymph:** | **[ ] Normal** | **[ ] Abnormal** |  |
|  |
| **Skin:** | **[ ] Normal** | **[ ] Abnormal** |  |
|  |
| **Neurologic:** | **[ ] Normal** | **[ ] Abnormal** |  |
|  |
| **Additional Findings:** |
| **Impression and Treatment Recommendations:** |
|  |
|  |
| Provider Name and credentials: |
| **Provider Signature:** | Date |
| Client: | Client ID |