| 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 |