History and physical (H&P) form

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HISTORY AND PHYSICAL

Patient _____

Age and sex _____

Date and time _____

Author _____

Source of history _____

Reliability of history _____

Referring provider _____

CHIEF COMPLAINT

In the patient's words:

HISTORY OF PRESENT ILLNESS

Onset (when and how it began):

Location:

Duration and pattern:

Character (what it feels like):

Aggravating factors:

Relieving factors:

Timing (constant, comes and goes, time of day):

Severity (0 to 10, and effect on activities):

Associated symptoms:

Treatments tried and their effect:

Relevant negatives:

PAST MEDICAL HISTORY

Conditions, with dates where known:

Hospital stays:

Immunizations:

PAST SURGICAL HISTORY

Procedures and dates:

MEDICATIONS

Name, strength, how it is taken (as reported or from records), including over-the-counter and supplements:

ALLERGIES

Substance and reaction:

FAMILY HISTORY

Conditions in parents, siblings and children:

Relevant causes of death:

SOCIAL HISTORY

Living situation, occupation, education:

Tobacco, alcohol and other substance use (type, amount, duration):

Sexual history and travel, as relevant:

Diet, exercise, safety at home:

REVIEW OF SYSTEMS

Constitutional (fever, weight change, fatigue):

Eyes, ears, nose and throat:

Cardiovascular:

Respiratory:

Gastrointestinal:

Genitourinary:

Musculoskeletal:

Skin:

Neurological:

Psychiatric:

Endocrine:

Blood and lymph:

Allergy and immune:

Other systems not listed are negative: [ ] yes [ ] no

PHYSICAL EXAMINATION

Vital signs

General appearance:

Head, eyes, ears, nose and throat:

Neck:

Cardiovascular:

Respiratory:

Abdomen:

Musculoskeletal:

Skin:

Neurological:

Psychiatric:

Other (genitourinary, rectal, breast, lymph nodes, if indicated):

DATA

Laboratory results:

Imaging and other tests:

Previous records reviewed:

ASSESSMENT

Summary statement (age, key history, key findings):

Problem list, in order of importance, each with a differential diagnosis or working diagnosis:

PLAN

For each problem: tests, treatment, consults, patient education:

Disposition (admit, discharge, follow-up) and time frame:

Signature and credentials:

Educational template, not medical or legal advice. Follow your employer and regulator rules.