History and physical (H&P) template

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HISTORY AND PHYSICAL (H&P)

Patient

Date and time

Clinician

Source of history and reliability

CHIEF COMPLAINT

The main problem, in the patient's words:

HISTORY OF PRESENT ILLNESS

Onset, location, duration, character:

What makes it better or worse, radiation, timing, severity:

Related symptoms, and relevant symptoms that are absent:

What has been tried so far:

PAST MEDICAL AND SURGICAL HISTORY

Ongoing conditions:

Operations and hospital stays, with dates:

MEDICATIONS

Current medications, as reported or from records:

ALLERGIES

Allergen and type of reaction:

FAMILY HISTORY

Relevant conditions in close relatives:

SOCIAL HISTORY

Tobacco, alcohol and drug use:

Occupation, living situation, who is at home:

Function and independence:

REVIEW OF SYSTEMS

Positives and pertinent negatives by body system:

PHYSICAL EXAMINATION

Vital signs (temperature, heart rate, blood pressure, respiratory rate, oxygen saturation):

General appearance:

Head, eyes, ears, nose, throat and neck:

Heart and lungs:

Abdomen:

Limbs and skin:

Neurological:

RESULTS

Tests already available (bloods, imaging, ECG):

ASSESSMENT

One-line summary of the patient and the problem:

Problem list, most important first, with likely causes:

PLAN

For each problem: tests, treatment, monitoring, referrals:

Patient informed and agrees to plan:

Signature and credentials: