Admission date: _______________
Exam date: _______________

Chief Complaint/Proposed Procedure: __________________________________________

History of Present Illness: ___________________________________________________

Past Medical/Surgical Hx: ___________________________________________________
Allergies: __________________________________________________________________

Social History: ______________________________________________________________
Medications: __________________________________________________________________

Family History: __________________________________________________________________

<table>
<thead>
<tr>
<th>Functional Inquiry System</th>
<th>Comment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>□ Negative</td>
</tr>
<tr>
<td>HEENT</td>
<td>□ Negative</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>□ Negative</td>
</tr>
<tr>
<td>Respiratory</td>
<td>□ Negative</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>□ Negative</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>□ Negative</td>
</tr>
<tr>
<td>Neurological</td>
<td>□ Negative</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>□ Negative</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>□ Negative</td>
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<tr>
<td>Endocrine</td>
<td>□ Negative</td>
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<tr>
<td>Skin</td>
<td>□ Negative</td>
</tr>
<tr>
<td>Hematologic</td>
<td>□ Negative</td>
</tr>
<tr>
<td>Immunologic</td>
<td>□ Negative</td>
</tr>
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</table>

(Medical Staff Records)
Physical Exam:

<table>
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<tr>
<th>B/P R:</th>
<th>B/P L:</th>
<th>Pulse:</th>
<th>Resp:</th>
<th>Temp:</th>
<th>Height:</th>
<th>Weight:</th>
</tr>
</thead>
</table>

Comments

General
- Well developed & well nourished
- No acute distress

HEENT
- PERRLA
- Hearing non-impaired
- Oral mucosa moist, no cyanosis

Neck
- No jugular vein distention
- Normal thyroid
- No masses or adenopathy

Cardiovascular
- Regular rate & rhythm
- All pulses normal, equal & synchronous
- S1 S2 normal
- No bruits
- Normal PMI

Respiratory
- No rales, rhonchi or wheezing
- No use of accessory muscles

Abdomen
- No masses or tenderness
- Bowel sound active
- No hepatosplenomegaly
- Rectal exam normal (if applicable)

Genitourinary
- Normal external exam
- Normal internal exam (if applicable)

Skin/Musculoskeletal
- No edema
- No muscle atrophy
- No rashes, ulcers or skin lesions
- No joint abnormality

CNS/Neuro
- Cranial nerves intact
- Deep tendon reflexes 2+ bilaterally

Mental Status
- Alert & oriented x3
- No disturbance of affect

Impressions: ____________________________________________

Diagnosis: ____________________________________________

Plan: ____________________________________________

Physician signature: ___________________________ Date: ___________ Time: ___________________________

Resident signature: ___________________________ Date: ___________ Time: ___________________________

Complete the following information if updating an H&P that was completed within the last 30 days.

I have examined this patient, reviewed the H&P, and there are:
- [ ] no changes to the patient’s condition since the H&P was completed.
- [ ] the following updates to the H&P: ____________________________________________

_________________________ ___________________________
Physician signature: Date: Time: ___________________________