# HISTORY AND PHYSICAL PRE-PRINTED FORM

DATE: _____

NAME: _____ AGE: _____ SEX: M / F

HISTORY OF PRESENT ILLNESS (CHIEF COMPLAINT): _____

_____

_____

ALLERGIES/REACTIONS: _____

CURRENT MEDICATIONS: _____

_____

HISTORY:

MEDICAL/SURGICAL: _____

_____

FAMILY: _____

SOCIAL: _____

REVIEW OF SYSTEMS: _____

_____

PHYSICAL EXAMINATION:

| | | | |
|---|---|---|---|
| | HEIGHT: _____ | WEIGHT: _____ | TEMPERATURE: _____ |
| VITAL SIGNS: | BLOOD PRESSURE: _____ | PULSE: _____ | RESPIRATIONS: _____ |
| MENTAL STATUS: | | | |
| HEENT: | | | |
| CHEST: | | | |
| HEART: | | | |
| ABDOMEN: | | | |
| EXTREMITIES: | | | |
| OTHER PERTINENT INFORMATION | | | |

DIAGNOSIS: _____

_____

PROPOSED SURGERY/PROCEDURE (PLAN): _____

_____

CLEARED FOR SURGERY: ☐ YES ☐ NO

_____ _____ _____

Physician Signature Date Time

**Palms West Hospital**
**Loxahatchee, FL**

**HISTORY AND PHYSICAL PRE-PRINTED FORM**

Patient Identification

*HPS*

PWH-600-00145 REV. 10/10