H&P is to be completed within 30 days of the procedure/admit.

Chief Complaint/History of Present Illness: ____

____

Meds/Dosages/Frequency: ____________________

____

____

____

____

____

Allergies: ____________________

____

Smoking/Drugs/Alcohol: ____________________

Anesth/Surg Complications: ____________________

Family History: ____________________

Social History: ____________________

Past Medical/Surgical History: (check if present)

Cardiac: ☐ CHF ☐ CAD ☐ Dysrhythmia ☐ Valve Disease ☐ Hypertension **Renal:** ☐ CRF ☐ Stones

Diabetes: ☐ IDDM ☐ NIDDM **Lung:** ☐ COPD ☐ Asthma ☐ TB **Neuro:** ☐ Neuropathy ☐ Dementia ☐ Seizures ☐ CVA

Anemia: ☐ Bleeding Problems ☐ Previous Transfusions **Joint:** ☐ Pain ☐ Back Problems **Hepatic:** ☐ Hepatitis

Other Illnesses: ____

Previous Surgeries: ____

____

____

PHYSICAL EXAMINATION (See reverse side for Review of Body Systems, if admitted.) Check, if normal.

Vital Signs: Temperature ____________ Pulse ____________ Respiration ____________ BP ____________

Mental Status:	☐ Normal	Comments: ____________
General Condition:	☐ Normal	Comments: ____________
ENT:	☐ Normal	Comments: ____________
Neck:	☐ Normal	Comments: ____________
Heart:	☐ Normal	Comments: ____________
Lungs:	☐ Normal	Comments: ____________
Abdomen:	☐ Normal	Comments: ____________
Chest:	☐ Normal	Comments: ____________
Skin:	☐ Normal	Comments: ____________
Genitalia	☐ Normal	Comments: ____________
Extremities:	☐ Normal	Comments: ____________
Pelvic/Rectal:	☐ Normal	Comments: ____________
Neurological:	☐ Normal	Comments: ____________
Osteopathic Structural Exam:	☐ Normal	Comments: ____________

Diagnosis/Impression: ____________________

____

____

Planned Treatment/Procedure: ____________________

____

____

Physician
Signature____________________ MD/DO Printed Name____________________ Date__________Time__________

***CONDITION AT TIME OF SURGERY:**

I have examined the patient, reviewed the H & P and there are no changes to the H & P unless noted below.

____

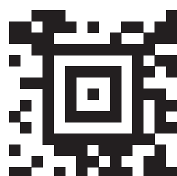
____

Physician
Signature____________________ MD/DO Printed Name____________________ Date__________Time__________

UPMC Pinnacle

PATIENT IDENTIFICATION

HISTORY & PHYSICAL EXAMINATION



Form INV 42537 (07/18) MR (InD)
Aztec Barcode 201032

If patient is an infant, child or adolescent (under 18 years old) the following must be addressed - growth & development, immunization status, educational needs, daily activity needs, and the family's or guardian's involvement.

Ht ___________ Wt ___________ Immunization Status ___________ Family or Guardian Involvement ________________________

Comments: ____

____

REVIEW OF BODY SYSTEMS (Check, as necessary)

1. ☐ Weakness ☐ Fatigue ☐ Gain of Weight ☐ Loss of Weight ☐ Change in Sleeping Habits ☐ Chills ☐ Fever ☐ Night Sweats.
   Comments: ____
2. ☐ Goiter ☐ Intolerance to Heat or Cold ☐ Changes in Voice ☐ Changes in Energy Level ☐ Changes in Urination
   ☐ Excessive Thirst ☐ Excessive Eating.
   Comments: ____
3. ☐ Skin Color Changes ☐ Tumor(s) ☐ Hair Changes ☐ Nail Changes ☐ Dermatitis ☐ Skin Lesions ☐ Itching.
   Comments: ____
4. ☐ Anemia ☐ Abnormal Bleeding ☐ Excessive Bruising ☐ Swollen Glands ☐ HIV.
   Comments: ____
5. ☐ Headache ☐ Dizziness ☐ Seizures ☐ Muscle Weakness ☐ Nervousness ☐ Depression ☐ Loss of Sleep ☐ Memory Loss
   ☐ Abnormal ☐ Fears ☐ Tremors ☐ Paralysis ☐ Double Vision ☐ Hyperventilation ☐ Inner Ear Problems
   ☐ Problems with Muscle Coordination.
   Comments: ____
6. ☐ Excessive Tearing ☐ Glaucoma ☐ Eye Infections ☐ Loss of Vision ☐ Crossed Eyes ☐ Bulging Eyes ☐ Deafness
   ☐ Earaches ☐ Draining Ears ☐ Ringing in the Ears ☐ Nose Bleeds ☐ Sinus Problems ☐ Nasal Discharge ☐ Postnasal Drip
   ☐ Soreness.
   Comments: ____
7. ☐ Dental Cavities ☐ Dentures ☐ Tooth Loss ☐ Inflammation of Gums ☐ Coughing ☐ Hoarseness ☐ Wheezing
   ☐ Respiratory Infections ☐ Positive TB Test ☐ Seasonal Allergies ☐ Blood in Sputum.
   Comments: ____
8. ☐ Chest Pain ☐ Breathing Difficulties ☐ Swelling of Arms or Legs ☐ Murmur ☐ Hypertension ☐ Dyspnea on Exertion.
   Comments: ____
9. ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Hemorrhoids ☐ Gas ☐ Stomach Pain ☐ Use of Antacids
   ☐ Use of Laxatives ☐ Blood in Stool ☐ Change in Appetite ☐ Change in Bowel Habits ☐ Ulcers ☐ Trouble Swallowing.
   Comments: ____
10. ☐ Kidney Stones ☐ Difficulty Starting or Stopping Urination ☐ Kidney Infections ☐ Urinary Urgency ☐ Frequent Urination
    ☐ Inability to Urinate.
    Comments: ____
11. ☐ Breast Masses/Lumps/Discharge ☐ Pain in Breast(s) ☐ Breast Ulceration(s).
    Comments: ____
12. Male: ☐ Discharge from Penis ☐ Mass in Testes ☐ Impotence ☐ Tumor(s) ☐ Infertility.
    Comments: ____
13. Female: ☐ Heavy Menstrual Flow ☐ Pregnancy ☐ Abortion ☐ Hysterectomy ☐ Amenorrhea ☐ Infertility.
    Comments: ____
14. ☐ Joint Swelling ☐ Back Problems ☐ Disc Problems ☐ Stiffness ☐ Arthritis ☐ Deformity ☐ Joint Pain ☐ Muscle Weakness
    ☐ Joint Redness.
    Comments: ____

Physician
Signature_______________________ MD/DO Printed Name_____________________Date_______Time_______

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PATIENT IDENTIFICATION

HISTORY & PHYSICAL EXAMINATION