PATIENT NAME: _____ **DATE:** _____

HISTORY	PHYSICAL EXAM
Chief Complaint:	**General Appearance:**
History of Present Illness: (Include Indications for procedure)	**Head, Eye, Ear, Nose & Throat:**
Past Medical History:	**Chest:**
	Lung:
	Breast:
Medications & Dosages:	**Heart:**
	Abdomen:
Allergies:	
	Genitalia:
Family & Social History:	**Pelvic:**
	Rectal:
Smoking	**Extremities:**
ETCH	**Neurologic:**
Drug	
Review of Systems:	
Cardiovascular	**IMPRESSION:**
Respiratory	
Gastrointestinal	
Genitourinary	
Musculoskeletal	
Neurological (include mental status)	**PLAN:**
EYE CASES ONLY:	
Visual Acuity	
Expected Outcome	

Signature _____ Date _____

(IMPRINT PATIENT'S PLATE)

HISTORY & PHYSICAL EXAMINATION