Ascension St. Vincent's

Facilities:
Ascension St. Vincent's Riverside
Ascension St. Vincent's Southside
Ascension St. Vincent's Clay County
Ascension St. Vincent's St. Johns County

Patient Label

HISTORY AND PHYSICAL

_____ Sex:_____ Race:_____

Chief Complaint or Purpose of Examination

History Present Illness (HPI)

Past Medical History (PMH)	Surgical History/Hospitalizations:
Allergies:	Current Medications:
Social History Marital Status: □ Single □ Married □ Seperated □ Divorced □ Widowed Habits (Smoking, Alcohol): Occupation:	
Family History	

Review of System (ROS)

Printed name other Healthcare Professional	Signature of other Heathcare Professional	Date	Time
Printed name of examining physician	**Signature of Examining Physician**	Date	Time

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Patient Label

HISTORY AND PHYSICAL

Respiration:_____ Blood Pressure: _____

Height: _____
Weight: _____

Findings

Normal	Abnormal	COMMENTS
_____	_____HEENT	
_____	_____NECK	
_____	_____CHEST	
_____	_____HEART	
_____	_____BREASTS	
_____	_____ABDOMEN	
_____	_____GENITALIA	
_____	_____EXTREMITIES	
_____	_____BACK&SPINE	
_____	_____NERVOUS SYSTEM	
_____	_____RECTUM	

Significant Laboratory Tests, X-ray Reports, or EKG Findings

Impression	Plan of Treatment

Printed name other Healthcare Professional | Signature of other Heathcare Professional | Date | Time

Printed name of examining physician | **Signature of Examining Physician** | Date | Time