«PatientNumber»

«PatientNumber»

«PatientName» **«MotherIdentifier»**

«BirthDate» «Gender» «Age»«AgeCode»
«SpecialProgramCode» «Location» «Room»
«FinClass»

UMC HEALTH SYSTEM

UNIVERSITY MEDICAL CENTER
LUBBOCK, TEXAS
PHYSICIAN'S HISTORY & PHYSICAL

ADMISSION PATIENT HISTORY

Date: _____

CHIEF COMPLAINT: _____

HPI: _____

MEDS/DOSE/FREQUENCY:

ALLERGIES/RESPONSE:

Tobacco: _____
ETOH: _____
Drugs: _____

PMH: _____

PSH: _____

Ob/Gyn: _____ **Psychiatric:** _____

Immunizations: ❑ Pneumonia ❑ Flu ❑ Tetanus _____

Development:

Family History: (specify family member affected, age of death)

HTN	MI/CAD	Thyroid	Alcoholism
DM	CVA	TB	Substance Abuse
Ca	Renal	Suicide	Other

Personal/Social History: Born in _____ Education _____ Occupation _____

Home Situation/Interests: _____

ROS

☑ = Negative; If Positive, describe:	☑ = Negative; If Positive, describe:
☐ Constitutional	☐ Musculoskeletal
☐ Eyes	☐ Skin/Breasts
☐ ENT/Mouth	☐ Neurological
☐ Cardiovascular	☐ Psychiatric
☐ Respiratory	☐ Endocrine
☐ Gastrointestinal	☐ Hematol/Lymph
☐ Genitourinary	☐ Allergic/Immun.

«PatientNumber»

«PatientNumber»

«PatientName» **«MotherIdentifier»**

«BirthDate» «Gender» «Age»«AgeCode»
«SpecialProgramCode» «Location» «Room»
«FinClass»
«DoctorName» «LabelPrintDate»

UMC HEALTH SYSTEM

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PHYSICIAN'S HISTORY & PHYSICAL

ADMISSION PHYSICAL EXAM, ASSESSMENT & PLAN

PE: General: _____ Pain (0-10) _____

Temp: _____ HR: _____ BP: _____ RR: _____ HT: _____ WT: _____ FOC: _____

Skin: _____

HEENT: _____

Neck/Lymph Node: _____ Breasts: _____

Lungs: _____

CV: _____ JVP: _____ Carotid Upstrokes: _____ Bruits Y/N: ____ PMI: _____

S1/S2: _____ Murmurs: _____ Other: _____

Abdomen: _____

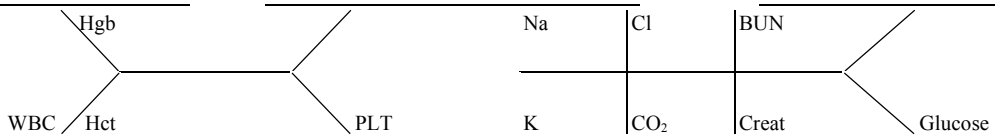
Pelvic/GU: _____

Extremities/Musculoskeletal: _____

Neuro: Oriented (x): _____ CrN: _____ Motor: _____

Cerebellar: _____ Sens: _____ Reflexes: _____

LAB/XRays/EKG:



IMP/Plan: (Include Differential Diagnosis)

ATTENDING PHYSICIAN SIGNATURE DATE TIME

RESIDENT PHYSICIAN SIGNATURE DATE TIME