Methodist Healthcare

HISTORY AND PHYSICAL DOWNTIME FORM

HISTORY:

Allergies: (allergy to food/drugs and include reaction(s):
(allergies): _____

Chief Complaint: _____
History of present illness:
_____
_____
_____
_____
_____
_____

Review of Systems: (circle pertinent positives)

Constitutional	Fever, chills, weight loss, weight gain, fatigue, malaise	Musculoskeletal	Muscle weakness, muscle pain, joint stiffness, joint pain, range of motion, swelling
Eyes	Itching, burning, tearing, discharge, foreign body, glasses, vision changes, diplopia	Endocrine	Heat/cold intolerance, excessive sweating, polydipsia, polyphagia, polyuria, poor growth, hirsutism, hair loss
Mouth/ENT	Earache, ear drainage, runny nose, sneezing, congestion, sore throat, hoarseness, nosebleed, hearing loss, bleeding gums, dental caries	Hematologic	Anemia, bruising, petechiae, purpura, bleeding, transfusions, pica
Cardiovascular	Murmur, chest pain, palpitations, edema, dyspnea with exertion, orthopnea, hypertension, irregular rhythm	Neurologic	Headache, dizziness, vision changes, vertigo, head trauma, seizures, fainting, numbness, tingling, tremors, weakness, paralysis
Respiratory	Shortness of breath, wheezing, cough, hemoptysis	Psychiatric	Mood, memory, orientation, depression, suicidal ideation, homicidal ideation
Gastrointestinal	Nausea, vomiting, appetite change, diarrhea, constipation, abdominal pain, bleeding, jaundice	Skin	Rash, itching, sores, lumps, moles, urticaria
Genitourinary	Discharge, itching, dysuria, frequency, urgency, hesitancy, polyuria, nocturia, hematuria, incontinence, stones, hernia, bleeding, pelvic pain	Immunologic	Frequent infections, lymphadenopathy

Past Medical and Surgical History:

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Current Medications:

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Pertinent Family History: _____
_____
_____

Pertinent Social History (circle applicable):
Alcohol Use: Y N Amount Used: _____ When stopped _____
Tobacco Use: Y N Amount smoked: _____ When stopped _____
Other Drugs: _____
Other pertinent social issues: _____

Physician Signature: _____ ID#: _____ Date: _____ Time: _____

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PHYSICAL EXAMINATION:

Vital Signs: T_____ HR_____ RR ____ BP_____

Please "x" pertinent normal or describe pertinent abnormal

	Normal	Abnormal (describe)		Normal	Abnormal (describe)
General			Lungs*		
Head			Abdomen		
Eyes			Liver		
Ears			Spleen		
Nose			Extremities		
Mouth/ throat			Genitalia		
Neck			Spine		
Nodes			Skin		
Heart*			Neurologic		
Pulses			Rectal		

***Required**

Other abnormal physical examination findings:

_____

_____

_____

Laboratory Findings:

Wbc _____ Na _____ _____ _____ _____

Hct/hgb _____ K _____ _____ _____ _____

Platelet _____ CO2 _____ _____ _____ _____

Glucose _____ BUN/Creat _____ _____ _____ _____

Radiographic Findings:

_____ _____

_____ _____

_____ _____

_____ _____

Impression/Documentation of medical decision-making: _____

_____

_____

_____

Plan of Care: _____

_____

_____

_____

House Staff Signature: _____ **ID#** _____

Signature of Credentialed Physician Who Performed H&P: _____ **ID#** _____

Allied Health Professional Who Recorded H&P: _____ **ID#** _____

Date: _____ **Time:** _____