

**THE CHRIST HOSPITAL**

CINCINNATI, OHIO 45219

**HISTORY AND PHYSICAL EXAMINATION**

**NAME:**

**DOB:**

**THE FOLLOWING ABBREVIATIONS ARE NOT PERMITTED FOR USE: IU,U (Units), QD (Daily), QOD (Every other day), 1.0 (1), .5 (0.5), MS, MS04, MgSO4 (Morphine Sulfate, Magnesium Sulfate)**  
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ADMITTING/TESTING FAX # 585-1273

DATE OF EXAM \_\_\_\_\_

REASON FOR ADMISSION/INDICATION FOR PROCEDURE: \_\_\_\_\_

HISTORY OF PRESENT ILLNESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DRUG OR OTHER SIGNIFICANT ALLERGIES: \_\_\_\_\_

FAMILY AND SOCIAL HISTORY: \_\_\_\_\_

PAST HISTORY: \_\_\_\_\_

DIABETES: no \_\_\_ yes \_\_\_: Hx. Steroid Rx: no \_\_\_ yes \_\_\_: Hx. of Diuretic Rx: no \_\_\_ yes \_\_\_

Bleeding Tendency: no \_\_\_ yes \_\_\_

CURRENT MEDICATIONS	NAME	DOSE	FREQUENCY

ALL YES ANSWERS REQUIRE COMMENT:

R.O.S.: Pain of Discomfort no \_\_\_ yes \_\_\_ specify

Weight loss: no \_\_\_ yes \_\_\_

**CARDIOVASCULAR:**

Chest pain no \_\_\_ yes \_\_\_

Hx of MI no \_\_\_ yes \_\_\_

Syncope no \_\_\_ yes \_\_\_

Hx. of Deep Vein Thrombosis no \_\_\_ yes \_\_\_

Other pertinent sx. no \_\_\_ yes \_\_\_

**RESPIRATORY**

Hx of Asthma no \_\_\_ yes \_\_\_

Cough no \_\_\_ yes \_\_\_

Smoke no \_\_\_ yes \_\_\_

Other pertinent sx. no \_\_\_ yes \_\_\_

**NEUROLOGICAL**

Hx of transient neurological sx. no \_\_\_ yes \_\_\_

Other pertinent symptoms no \_\_\_ yes \_\_\_

**RENAL**

Hx: Kidney or bladder disease no \_\_\_ yes \_\_\_

Other pertinent symptoms no \_\_\_ yes \_\_\_

**GASTROINTESTINAL:**

Abdominal pain no \_\_\_ yes \_\_\_

Nausea no \_\_\_ yes \_\_\_

Hx of Hepatitis no \_\_\_ yes \_\_\_

Alcohol use no \_\_\_ yes \_\_\_

Other pertinent sx. no \_\_\_ yes \_\_\_

**REPRODUCTIVE:**

Last Menstrual Period Date:

OTHER: (Musculoskeletal, endocrine, GU etc) \_\_\_\_\_



PHYSICAL EXAMINATION:

TEMP ____ PR ____ PESP ____ BP ____
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GENERAL APPEARANCE:

MENTAL STATUS:

HEENT:

NECK:

Bruits: no \_\_\_\_ yes \_\_\_\_

CHEST AND LUNGS"

Breasts: no \_\_\_\_ yes \_\_\_\_

HEART:

Murmur: no \_\_\_\_ yes \_\_\_\_

ABDOMEN:

PELVIC/RECTAL/INGUINO GENITAL:

EXTREMITIES:

Venous Stasis no \_\_\_\_ yes \_\_\_\_

NEUROLOGICAL

DIAGNOSIS \_\_\_\_\_

ASSESSMENT/PLAN:

SIGNATURE: \_\_\_\_\_ NAME PRINTED: \_\_\_\_\_  
Date/Time \_\_\_\_\_