Last Name: _____ DOB_____/_____/_____ Age_____ Visit Date_____/_____/_____

First Name: _____ Sex M ☐ F ☐ ☐ New ☐ Consultation ☐ Established
Exam Dr_____ Ref Dr_____

CHIEF COMPLAINT

HPI

Loc		**Modifying Factors**	
Qual			
Sever			
Dur		**Signs & Symptoms**	
Timing			
Cntx			

ROS

Constitutional	**Skin/Breast**	**Psychiatric**	**Eyes**	**Neurological**
	Skin Type 1 2 3 4 5 6 Sunburns ☐N ☐Y 0 2 5 >10			
GI	**Lungs/Resp**	**Musculoskeletal**	**Allergic/Immuno**	**ENT**
Endocrine	**Cardiovascular**	**Genitourinary**	**Lymph/Hemato**	**☐All Others Negative**

ROS No Done ☐ Reviewed ROS Dated _____/_____/_____ ☐ No Change

PFSH

☐ M ☐ W ☐ S ☐ D Children_____ Could you be pregnant now? ☐ Y ☐ N Occupation_____

Allergies	**Medications**	**Medical Illness**	**Surgeries**	**Family History**	**Social History**
	Including birth control pills				**Tobacco ☐ Y ☐ N**
					Alcohol ☐ Y ☐ N
					III Drug ☐ Y ☐ N
None ☐	**None ☐**	**None ☐**	**None ☐**	**None ☐**	

PFSH Not Done Reviewed PFSH Dated _____/_____/_____ ☐ No Change Hobbies ☐ Y ☐ N Exercise ☐ Y ☐ N

Changes in Conditions_____

_____Staff Initials _____(Physician Initials)