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

«PatientNumber»
«PatientNumber»
«PatientName» «MotherIdentifier»
«BirthDate» «Gender» «Age»«AgeCode»
«SpecialProgramCode» «Location» «Room»
«FinClass»

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

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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: ______

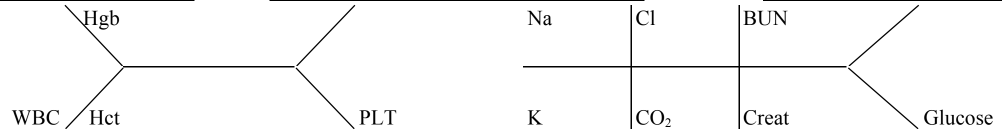
Pelvic/GU: ______

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

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