

<p>1. <b>General Information</b></p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____</p> <p>State: _____</p> <p>Zip: _____</p> <p>Phone: _____</p>					
<p>2. <b>Medical History</b></p> <p>Current Conditions: _____</p> <p>Previous Conditions: _____</p> <p>Surgeries: _____</p> <p>Allergies: _____</p> <p>Medications: _____</p>					
<p>3. <b>Family History</b></p> <p>Parents: _____</p> <p>Siblings: _____</p> <p>Spouse: _____</p> <p>Children: _____</p>					
<p>4. <b>Physical Examination</b></p> <p>Height: _____</p> <p>Weight: _____</p> <p>Blood Pressure: _____</p> <p>Heart Rate: _____</p> <p>Respiratory: _____</p> <p>Abdominal: _____</p> <p>Neurological: _____</p>					
<p>5. <b>Diagnostic Test Results</b></p> <p>X-rays: _____</p> <p>Lab Tests: _____</p> <p>ECG: _____</p> <p>Other: _____</p>					
<p>6. <b>Immunization Status</b></p> <p>MMR: _____</p> <p>Tdap: _____</p> <p>Polio: _____</p> <p>Other: _____</p>					
<p>7. <b>Current Health Status</b></p> <p>Presenting Complaint: _____</p> <p>Duration: _____</p> <p>Severity: _____</p> <p>Associated Symptoms: _____</p>					
<p>8. <b>Review of Systems</b></p> <p>Constitutional: _____</p> <p>Cardiovascular: _____</p> <p>Respiratory: _____</p> <p>Gastrointestinal: _____</p> <p>Genitourinary: _____</p> <p>Neurological: _____</p> <p>Musculoskeletal: _____</p> <p>Skin: _____</p>					
<p>9. <b>Assessment and Plan</b></p> <p>Assessment: _____</p> <p>Plan: _____</p> <p>Follow-up: _____</p>					
<p>10. <b>Signature and Date</b></p> <p>Physician: _____</p> <p>Date: _____</p>					

