

Date: _____

Phone: (816) 855-1841

Fax: (816) 302-9928

PATIENT INFORMATION

First Name: _____ Last Name: _____ Gender: _____ DOB: ____/____/____

INFORMANT

First Name: _____ Last Name: _____ Relationship: _____

Chief Complaint: _____

History of Present Illness (HPI): _____

Past Medical/Surgical History/Family History/Problem List: _____ Birth Weight: _____ kg

REVIEW OF SYSTEMS

Constitutional: _____

HEENT: _____

Respiratory: _____

Cardiovascular: _____

Gastrointestinal: _____

 Genitourinary: _____ LMP: ____/____/____ ☐ Pre-menarchal

Heme/Lymph: _____

Endocrine: _____

Immunologic: _____

Musculoskeletal: _____

Integumentary: _____

Neurologic: _____

Psychiatric: _____

Smoking/Drugs/Alcohol Use/Abuse: _____

☐ All other ROS negative except those in HPI (at least 10 systems reviewed)

Adverse Reactions: ☐ NKAR Adverse Reaction(s): _____ Type of Reaction: _____

Medications/Vitamins/Supplements (prescribed and over the counter): ☐ None ☐ Medication List attached

Immunizations Up-to-Date: ☐ Current per ACIP and reviewed ☐ Not Current per ACIP-record reviewed

☐ Current per caregiver-record not available to be reviewed ☐ Patient/caregiver declines vaccines ☐ Other: _____

PHYSICAL EXAM

Vital Signs: Temp: _____ Pulse: _____ Resp. Rate: _____ Blood Pressure: ____/____ Current Weight: _____ kg Height: _____ cm

General: _____

HEENT: _____

Neck/Lymphatics: _____

Respiratory: _____

Cardiovascular: _____

Gastrointestinal: _____

Genitourinary: _____ Genitalia/Tanner Stage: _____

Musculoskeletal: _____

Integumentary: _____

Neurologic: _____

Psychiatric: _____

☐ Patient is medically clear for surgery/procedure Other: _____

Laboratory/Radiology/Ancillary Results: ☐ None

Assessment/Plan: _____

Provider Signature: _____ Printed Name: _____ Date: ____/____/____ Time: _____ a.m./p.m.

Practice/Organization where the form was completed: _____