

PATIENT NAME: _____ PATIENT AGE: _____ DATE: _____

30-DAY HISTORY & PHYSICAL EXAMINATION ATTESTATION

I HEREBY CERTIFY THAT THE PATIENT'S RELEVANT HISTORY AND PHYSICAL EXAMINATION IS SUBSTANTIALLY UNCHANGED FROM THE DATE AND TIME I PERFORMED THE EXAMINATION.

Physician Signature: _____ Date: _____

DOCUMENT ONLY CHANGES TO THE PATIENT'S CONDITION OR COMPLETE ENTIRE FORM IF H&P PERFORMED MORE THAN 30 DAYS AGO

PLANNED PROCEDURE: _____

INDICATIONS FOR PROCEDURE *(Include symptoms, risk assessment & co-morbidities):* _____

ALLERGIES: Yes No If yes, list and define type of reaction: _____

CURRENT MEDICATIONS & DOSAGES: _____

PAST MEDICAL, SOCIAL & FAMILY HISTORY *(Include anesthesia related and tobacco & alcohol use):*

Contributory Non-Contributory Define if contributory: _____

CURRENT ASSESSMENT AND RESULTS OF PRIOR RELATED DIAGNOSTIC STUDIES:

(Abnormal findings require comments)

VITAL SIGNS: BP: _____ P: _____ R: _____ T: _____

	Not				Not				
	Normal	Abnormal	Pertinent		Normal	Abnormal	Pertinent		
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gynecological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdominal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Urologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integumentary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cardiology/EKG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Radiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

PROVISIONAL DIAGNOSIS: _____

Physician Signature: _____ Date: _____

**LEE MEMORIAL HEALTH SYSTEM
Lee County, Florida**

**ADMISSION / PRE-PROCEDURE
HISTORY & PHYSICAL**

120134196-0553 5/07 Linked to Policy [M10 02 378](#)

UCO TAB - HISTORY & PHYSICAL