Millennium Healthcare of Clifton
925 Clifton Ave; Suite 201
Clifton, NJ 07013
973-249-7700

History and Physical

Chief Complaint: _____

Past Medical History: _____

Surgical History: _____

Social History: _____

Allergies / Reactions: _____

Current Medications: ☐ Patient is taking no medication(s). ☐ Patient is taking medication(s). See attached list.

Review of Systems: (Explain any abnormal findings.)

Cardiac / Circulatory:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Endocrine:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Gastrointestinal:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Genitourinary:	☐ WNL	☐ Deferred	☐ Abnormal	_____
HEENT:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Integumentary:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Musculoskeletal:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Neurological:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Respiratory:	☐ WNL	☐ Deferred	☐ Abnormal	_____

Physical Exam: (Explain any abnormal findings.)

Height: _____ Weight: _____
Vital Signs: Blood Pressure: _____ Pulse: _____ Respirations: _____ Temperature: _____

Abdomen:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Chest:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Heart:	☐ WNL	☐ Deferred	☐ Abnormal	_____
HEENT:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Extremities:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Lungs:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Mental / Neurological Status:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Pelvic / Rectal:	☐ WNL	☐ Deferred	☐ Abnormal	_____
Skin:	☐ WNL	☐ Deferred	☐ Abnormal	_____

Additional Findings / Comments: _____

General Condition: ☐ Good ☐ Abnormal _____

Pre-Operative Diagnosis: _____

Proposed Surgery/Procedure: _____

Physician's Signature: _____ ***Date:*** _____

Office Stamp

Pre-Procedure Update: (H&Ps must be written within 30 days of the procedure and include a pre-procedure update on DOS)

Height: _____ Weight: _____
Vital Signs: Blood Pressure: _____ Pulse: _____ Respirations _____ Temperature: _____

Date H&P Performed: _____ ☐PAT Testing reviewed ☐ No PAT Testing Ordered

ADVANCE DIRECTIVE ☐ Y ☐ N ☐ on chart ☐ **Patient is taking no medication(s)** ☐ **Patient is taking medication(s). See attached list.**

☐ I have reviewed the H&P and allergies to medications and biologicals. ***No changes to the previous history and physical exam or status have occurred since it was completed.***

☐ I have reviewed the H&P and allergies to medications and biologicals. ***The following changes to the previous history and physical exam or status have occurred since it was completed:*** _____

_____

Physician's Signature: _____ ***Date:*** _____

R15

revised: 4/23/15