



PT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
GENDER: \_\_\_\_\_ AGE: \_\_\_\_\_  
DATE: \_\_\_\_\_ TIME: \_\_\_\_\_  
HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  
B/P: \_\_\_\_\_ TEMP: \_\_\_\_\_ PULSE: \_\_\_\_\_ SPO2: \_\_\_\_\_ %  
ALLERGIES: \_\_\_\_\_ PMH: \_\_\_\_\_  
FAMILY MEDICAL HISTORY: \_\_\_\_\_  
SURGERIES: \_\_\_\_\_  
SMOKING: \_\_\_\_\_ TOBACCO: \_\_\_\_\_ ALCOHOL: \_\_\_\_\_ DRUGS: \_\_\_\_\_  
MARRIED: \_\_\_\_\_ CHILDREN: \_\_\_\_\_ WORKING: \_\_\_\_\_  
MEDICATIONS: \_\_\_\_\_  
CHIEF COMPLAINT: \_\_\_\_\_  
LMP: \_\_\_\_\_ PREGNANT: \_\_\_\_\_ BREAST FEEDING/LACTATING: \_\_\_\_\_  
LAST PAP: \_\_\_\_\_ LAST MAMMO: \_\_\_\_\_ MALES LAST PSA: \_\_\_\_\_  
PHARMACY NAME: \_\_\_\_\_ CROSS STREETS: \_\_\_\_\_  
\_\_\_\_\_

**DR. NOTES:**

**MEDICATIONS/INJ:**

**SAMPLES/RX:**

**IMAGING/LAB ORDER:**

**PROCEDURES:**

**CHECK OUT:**

F/U APPT: 1 WK 2 WK 1 MO 3 MO

PROCEDURES/INJECTIONS DONE: \_\_\_\_\_

LABS F/U: LAB PKG STD OTHER:

ADDED MISC: \_\_\_\_\_