Template for Dictating a History and Physical

State your name, Patient Name, Patient MRN and FIN, Admitting Attending, Date of service

Date: Patient Name: Patient MR/FIN: PCP: Code Status: Surrogate Decision Maker:  

Chief Complaint: Reason for Admission: History of Present Illness: (Location, Severity, Timing, Quality, Duration, Context, Modifying factors, Associated signs & symptoms—minimum 4 of 8)

Past / Family / Social History (must include all 3) Past Medical / Surgical Hx/Chronic Medical Issues: Social History: Tobacco, ETOH, recreation drugs Functional status/ambulation Home, support system Family History: Allergies: Medications:  

Review of Systems: (need 10+ or reason not done) Constitutional - Fever, chills, malaise Eyes - Vision, pain ENT/mouth - Teeth, sore throat Cardiovascular - CP, palpitations, orthopnea Respiratory - SOB, cough, pleuritic CP GI - N/V/D, abd pain GU - Dysuria, hematuria Musculoskeletal - Myalgia, arthralgia, weakness Integumentary - Rashes, lesions Neurological - Focal weakness, numbness Psychiatric - Delusions, depression Endocrine - Polyuria, polydipsia Heme / lymph - Bruising, bleeding, LAD Allergy / immune - Seasonal, frequent infections  


Labs/Studies State if Radiology ordered / reviewed, Old / electronic chart reviewed  

Assessment/Plan by Problem (all admitting diagnoses, pertinent chronic problems. State reason for admission and what level of care): Hospital issues: DVTp Diet Ambulation Status Dispo

Bed Request Admit Orders Med Rec Code Status Note H&P or MRAN Update Cache Team Color ___