UCLA Health

MRN:
Patient Name:

(Patient Label)

HISTORY & PHYSICAL
LONG FORM / COMPREHENSIVE

(Comprehensive H&P required for all admissions $\geq$ 24 Hours

Date: **Time:** **Service:**

Chief Complaint:

History of Present Illness:

Allergies:

Medications:

Past Medical History: (N/C = non-contributory)	**N/C**	**CAD**	**CVA**	**HTN**	**DM**	**Other:**

Past Surgical History: **N/C** ☐

Family History: **N/C** ☐

Relevant Social History:	**N/C** ☐	**ETOH**	**IVDA**	**Tobacco _____ Packs x ______ yrs**

Review of Systems CHECK ALL APPROPRIATE BOXES

GENERAL:	☐ WNL	☐ Other
SKIN:	☐ WNL	☐ Other
ENT:	☐ WNL	☐ Other
EYES:	☐ WNL	☐ Other
CV:	☐ WNL	☐ Other
RESP:	☐ WNL	☐ Other
GI:	☐ WNL	☐ Other
GU:	☐ WNL	☐ Other
Muscl:	☐ WNL	☐ Other
Neuro:	☐ WNL	☐ Other
Hemat/Lymph:	☐ WNL	☐ Other

Examining Practitioner:	**Date:**	**Time:**	**Pager #:**
Attending MD:	**Date:**	**Time:**	**Pager #:**

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Allergic/Immuno:	☐ WNL	***Reactions to:***	☐ Drugs	☐ Food	☐ Insects	☐ Skin rashes
	☐ Trouble breathing		☐ Persistent infections		☐ HIV exposure	
Endo:	☐ WNL	☐ Diabetes	☐ Thyroid Dysfunction			
Psych:	☐ WNL	☐ Nervousness	☐ Anxiety	☐ Depression	☐ Previous psych care	☐ Hallucinations
Other:						

Physical Exam: CHECK ALL APPROPRIATE BOXES			**Vital Signs: B/P P R T**
General:	☐ WNL	☐ Other	**Height:** ______________ **Weight:** _______________
ENT:	☐ WNL	☐ Other	
Eyes:	☐ WNL	☐ Other	
Breasts:	☐ WNL	☐ Other	
Lungs:	☐ WNL	☐ Other	
Heart:	☐ WNL	☐ Other	
Abd:	☐ WNL	☐ Other	
Musculo-Skeletal:	☐ WNL	☐ Other	
Genitalia:	☐ WNL	☐ Other	
Neurologic:	☐ WNL	☐ Other	
Skin/wounds:	☐ WNL	☐ Other	

Labs:

Studies:

CXR:

EKG:

Impression:

Plan:

Examining Practitioner:	**Date:**	**Time:**	**Pager #:**
Attending MD:	**Date:**	**Time:**	**Pager #:**