



History and Physical

To be completed within 30 days of procedure / surgery

Patient Name: _____ DOB: _____

Allergies	
Medications	

Past Medical History

Cardiac

- CHF
- CAD
- Valve Disease
- Hypertension
- Dysrhythmia
- Other:

Diabetes

- NIDDM
- IDDM

Neuro

- CVA
- TIA
- Neuropathy
- Dementia
- Other

- Vital Signs: _____
- Skin: _____
- Head: _____
- Eyes: _____
- ENT: _____
- Lungs: _____
- GI/GU: _____
- Other: _____

Physician Name Printed: _____

Physician Signature: _____ Date: _____

NP/ PA Name Printed: _____

NP/ PA Signature: _____ Date: _____

***** SUPERVISING PHYSICIAN NEEDS TO CO-SIGN IF NP/PA DOES ASSESSMENT*****

PLEASE FAX BACK TO 618-628-4411 OR EMAIL TO OFFICEMANAGER@ALLGRINS4KIDS.COM

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