Patient Name:_____D.O.B._____ DOS _____INSURANCE_____

Pharmacy Information:_____

Chief Complaint:_____

Medication List:_____
_____

Allergies:_____
_____

Medical Hx:_____
_____

Surgeries:_____
_____

Hospitalization:_____
_____

Smoker: Yes_____No_____Never_____

Alcohol: Yes_____No_____Never_____

VITALS:B/P_____ RR_____ O2%_____ Pulse_____ Temp_____WT_____HT_____

HPI: _____

ROS: _____

ASSESMENT/DX:_____

PROCEDURE: _____
_____

TREATMENT:_____
_____
_____

VISIT CODE AND PROCEDURE CODE _____

NEXT APPOINTMENT: _____