

**RAINFOREST RECOVERY CENTER
HISTORY AND PHYSICAL**

(This form must be completed by your physician and completed within 30 days of admission)

Chief Complaint:/Present Illness: _____ _____		
Date of Last PPD: _____ (TB test must be within last year)		
Past History: _____ _____		
Family History: _____ _____		
Social/Occupational: _____ _____		
Systemic Review:		
Psychiatric _____ _____		
Head Injury _____ _____		
Resp. _____ _____		
Cardio. _____ _____		
GI _____ _____		
GU _____ _____		
CNS (History of Seizures, DT's) _____ _____		
Mus-skel _____ _____		
Skin _____ _____		
Current Medications: _____		
Allergies: _____		
Patient Name:	MRN:	Admit#:

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Examination:

WT _____ T _____ P _____ R _____ BP _____

Skin: _____

EENT: _____

Chest: _____

Heart: _____

Abdomen: _____

Pelvic and rectal: _____

CNS: _____

Extremities: _____

Medical Diagnosis:

Plan of Care:

Physician's Signature:

Date/Time:

Patient Name:

MRN:

Admit#: