PCP History & Physical

Patient Name:_____ DOB: _____

History of Present Illness:

_____

_____

_____

Past Medical History:

_____

_____

_____

Past Surgical History:

_____

_____

_____

Social History:

_____

_____

_____

Current Medications:

_____

_____

_____

Allergies:

_____

_____

_____

Height: _____ Weight:_____ BMI:_____ BP:_____

HEENT: _____

Neck: _____

Lungs: _____

Heart: _____

Extremities: _____

Abdomen: _____

Assessment: _____

Plan: _____

Recommend patient for bariatric surgery? [ ] YES [ ] NO

_____

Practitioner Signature Practitioner Name Date

Please FAX (209)846-9141