# **History and Physical Form**

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Address:	
Contact number:	
Physician/examiner:	
Date and time of examination:	
Examiner's signature:	
Patient information	
Name:	Date of birth:
Age:	Gender:
Patient ID:	
Insurance information:	
Patient's signature:	
Medical information	
Chief complaint/presenting complaint:	
History of chief/presenting complaint (symptoms and relevant risk factors):	
Medical history:	

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