

Third Party Assessor

History & Physical (H&P) Form

(If your office or practice has its own H&P form, it may be used in place of this form.
Please see delivery instructions bottom Page 2.)

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Vital Signs

Pulse: Resp: Temp: BP:

Ht: Wt:

Diagnosis(es) and ICD-9 code:

Current Medications (including OTC and supplements, if known):

Brief medical history, with specific attention to reasons for any disability (may be physical and/or cognitive/behavioral):

General/Constitutional:

Skin/Breast:

Eyes/Ears/Nose/Mouth/Throat:

Continued, History & Physical/Participant Name: _____

Cardiovascular:

Respiratory:

Gastrointestinal:

Genitourinary:

Musculoskeletal:

Neurologic/Psychiatric:

Allergic/Immunologic/Lymphatic/Endocrine:

Follow up/Comments:

Provider (MD, DO, CNP or PAC only) Signature and Title:

Date: _____

Office Telephone: _____

Please mail or Fax to:

Comagine Health – Third Party Assessor

PO Box 20910

Albuquerque, NM 87154-0910

Fax Line: (800) 251-9993 (Toll Free)