

# Good Faith Exam

## Patient information

Name:

Date of birth:

Gender:

Contact information:

Reason for visit:

## Medical history

Previous medical conditions:

Allergies:

Current medications:

Past surgeries or procedures:

Family medical history:

**Physical examination****Vital signs**

Blood pressure:

Heart rate:

Respiratory rate:

Temperature:

**General appearance**

Alert and oriented:

Well-nourished:

No acute distress:

**Systems examination**

Cardiovascular:

Respiratory:

Gastrointestinal:

Musculoskeletal:

Neurological:

Dermatological:

**Assessment and recommendations**

Summary of findings:

Assessment of suitability for procedure:

Risks and benefits discussion:

Recommendations:

Provider signature:

Date: