

Chief Complaint: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

History of Present Illness: \_\_\_\_\_

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## Review of Systems:

[ ] Unobtainable due to \_\_\_\_\_

	yes	no		yes	no		yes	no		yes	no
General: fatigue	[ ]	[ ]	CV: chest pain	[ ]	[ ]	GU: dysuria	[ ]	[ ]	Endo: polyuria	[ ]	[ ]
weight loss	[ ]	[ ]	edema	[ ]	[ ]	frequency	[ ]	[ ]	polydypsia	[ ]	[ ]
fever	[ ]	[ ]	PND	[ ]	[ ]	hematuria	[ ]	[ ]	polyphagia	[ ]	[ ]
chills	[ ]	[ ]	orthopnea	[ ]	[ ]	discharge	[ ]	[ ]	heat/cold intolerance	[ ]	[ ]
night sweats	[ ]	[ ]	palpitations	[ ]	[ ]	menstrual problems	[ ]	[ ]	Derm: rash	[ ]	[ ]
Eyes: visual change	[ ]	[ ]	claudication	[ ]	[ ]	Musc-skel: arthralgia	[ ]	[ ]	pruritis	[ ]	[ ]
pain	[ ]	[ ]	Resp: cough	[ ]	[ ]	arthritis	[ ]	[ ]	Neuro: weakness	[ ]	[ ]
redness	[ ]	[ ]	SOB	[ ]	[ ]	joint swelling	[ ]	[ ]	seizures	[ ]	[ ]
ENT: headaches	[ ]	[ ]	wheezing	[ ]	[ ]	myalgias	[ ]	[ ]	paresthasias	[ ]	[ ]
hoarseness	[ ]	[ ]	hypersomnolence	[ ]	[ ]	backpain	[ ]	[ ]	tremor	[ ]	[ ]
sore throat	[ ]	[ ]	GI: abdominal pain	[ ]	[ ]	Heme/Lymph: bleeding	[ ]	[ ]	syncope	[ ]	[ ]
epistaxis	[ ]	[ ]	stool changes	[ ]	[ ]	brusing	[ ]	[ ]	Psych: anxiety	[ ]	[ ]
sinus symptoms	[ ]	[ ]	nausea/vomiting	[ ]	[ ]	clotting	[ ]	[ ]	depression	[ ]	[ ]
hearing loss	[ ]	[ ]	diarrhea	[ ]	[ ]	transfusions	[ ]	[ ]	hallucinations	[ ]	[ ]
tinnitus	[ ]	[ ]	heartburn	[ ]	[ ]	lymph node swelling	[ ]	[ ]	All/Imm: hayfever	[ ]	[ ]
			blood in stool	[ ]	[ ]				bee sting allergy	[ ]	[ ]

Other ROS: \_\_\_\_\_

[ ] All other ROS reviewed and were NORMAL.

Past Medical History: \_\_\_\_\_

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Allergies: [ ] NKDA Other: \_\_\_\_\_

Medications: \_\_\_\_\_

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Past Surgical History: \_\_\_\_\_

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Family History: \_\_\_\_\_

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Social History: \_\_\_\_\_

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Cigs [ ] No [ ] Yes → Pack-yrs: \_\_\_\_\_

EtOH [ ] No [ ] Yes → Amount: \_\_\_\_\_

Illicits [ ] No [ ] Yes → Type: \_\_\_\_\_

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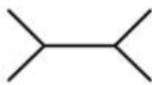
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Physical Exam		T _____	RR _____	BP _____	HR _____	Wt _____ (lbs)	Ht _____ (in)	BMI _____	O <sub>2</sub> Sat _____ on _____
<b>Eyes</b> <input type="checkbox"/> nl conjunctiva & lids <input type="checkbox"/> Pupils equal, round, & reactive <input type="checkbox"/> Fundus nl discs & vessels <input type="checkbox"/> Vision acuity & gross fields intact Abnormals:	<b>ENT</b> External <input type="checkbox"/> no scars, lesions, masses Otoscopic <input type="checkbox"/> nl canals, tympanic membranes Hearing <input type="checkbox"/> nl to finger rub Oropharynx <input type="checkbox"/> nl teeth, tongue, palate, pharynx Abnormals:	<b>Neck</b> External <input type="checkbox"/> no tracheal deviation Palpation <input type="checkbox"/> no masses or crepitus Thyroid <input type="checkbox"/> no 'megaly or tenderness Abnormals:							
<b>GI</b> Palpation <input type="checkbox"/> no masses or tenderness <input type="checkbox"/> no hep/splenomegaly Auscultation <input type="checkbox"/> nl bowel sounds Percussion <input type="checkbox"/> no shifting dullness Anus/rectum <input type="checkbox"/> no abnormality or masses <input type="checkbox"/> heme negative stool Abnormals:	<b>Resp</b> Effort <input type="checkbox"/> nl without retractions Percussion <input type="checkbox"/> no dullness or hyperresonance Palpation <input type="checkbox"/> no fremitus Auscultation <input type="checkbox"/> CTAB w/o W, R, or R Abnormals:	Skin <input type="checkbox"/> no rashes, lesions, ulcers <input type="checkbox"/> nl turgor Chest/Breast <input type="checkbox"/> nl inspection & palpation Lymph nodes <input type="checkbox"/> no axillary, inguinal, cervical, or submandibular LAD Genitourinary <input type="checkbox"/> nl external genitalia <input type="checkbox"/> nl vaginal tone, mucosa <input type="checkbox"/> no cervical motion tenderness <input type="checkbox"/> nl penis & scrotal contents <input type="checkbox"/> nl prostate size and texture Psych <input type="checkbox"/> nl cognition <input type="checkbox"/> MMSE _____ <input type="checkbox"/> nl mood and affect Abnormals:							
<b>CV</b> Palpation <input type="checkbox"/> PMI nondisplaced Auscultation <input type="checkbox"/> no murmur, gallop, or rub Carotids <input type="checkbox"/> nl intensity w/o bruit JVD <input type="checkbox"/> no jugulovenous distension Pulses <input type="checkbox"/> 2+/- femoral & pedal pulses Edema <input type="checkbox"/> no pedal edema Abnormals:	<b>Neuro</b> Orientation <input type="checkbox"/> A&O to person, place, time Cranial nerves <input type="checkbox"/> CN II-XII intact Sensory <input type="checkbox"/> nl sensation throughout Reflexes <input type="checkbox"/> 2+ + and symmetrical throughout Abnormals:								
<b>Musculoskeletal</b> Inspection ROM Strength Tone (✓ if normal) Abnormals: Upper extrem <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lower extrem <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gait <input type="checkbox"/> nl gait and station	<b>Other:</b> <input type="checkbox"/> no apparent distress								

## Labs:



Differential:  
 Neuts \_\_\_\_\_  
 Bands \_\_\_\_\_  
 Lymphs \_\_\_\_\_  
 Monos \_\_\_\_\_  
 Eos \_\_\_\_\_

Indices:  
 MCV \_\_\_\_\_  
 RDW \_\_\_\_\_  
 MCH \_\_\_\_\_  
 MCHC \_\_\_\_\_



Mag Phos Cal AlkPhos  
 GGT AST ALT NH4  
 Alb TotProt TotBili DirBili

Urinalysis:  
 SpGrav \_\_\_\_\_  
 Prot \_\_\_\_\_  
 Gluc \_\_\_\_\_  
 LE \_\_\_\_\_  
 Nit \_\_\_\_\_  
 WBC \_\_\_\_\_  
 RBC \_\_\_\_\_  
 Other: \_\_\_\_\_

X-ray:

EKG:

Other:

**Assessment & Plan:** \_\_\_\_\_  
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