



Name				PMH	PSH
MRN	Hospital Number				
CC:					
HPI:					
Chief Symptom	Onset	Location	Duration	Fam hx	Soc
Severity (1-10)	Aggravating Factors	Alleviating Factors	Associated Sx/RF	Meds	Allergies
ROS (check all that apply)				Physical exam	
General: <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight Loss/Gain HEENT: <input type="checkbox"/> Headache <input type="checkbox"/> Vision Changes <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sore Throat Respiratory: <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Hemoptysis Cardiovascular: <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Edema <input type="checkbox"/> Syncope Gastrointestinal: <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea Genitourinary: <input type="checkbox"/> Dysuria <input type="checkbox"/> Hematuria <input type="checkbox"/> Freq/Urg <input type="checkbox"/> Incontinence Musculoskeletal: <input type="checkbox"/> Joint/Back Pain <input type="checkbox"/> Muscle Weakness Neurological: <input type="checkbox"/> Dizziness <input type="checkbox"/> Paresthesias <input type="checkbox"/> Seizure Psychiatric: <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Memory Loss				T: ____ BP: / HR: ____ RR: ____ SpO2: ____% Gen <input type="checkbox"/> Well-developed, well-nourished <input type="checkbox"/> No acute distress <input type="checkbox"/> Cachectic <input type="checkbox"/> Obese HEENT/N: <input type="checkbox"/> Normocephalic <input type="checkbox"/> Eyes symmetrical, no erythema/discharge <input type="checkbox"/> Ears: Canals clear, TM intact, no effusion <input type="checkbox"/> Nares patent bilaterally, no discharge. <input type="checkbox"/> Oropharynx clear, no erythema or exudate <input type="checkbox"/> Oral mucosa pink/moist, lips pink/moist, no lesions <input type="checkbox"/> Neck supple, no masses <input type="checkbox"/> No JVD <input type="checkbox"/> No carotid bruits R: <input type="checkbox"/> Normal respiratory effort <input type="checkbox"/> Clear to auscultation bilaterally <input type="checkbox"/> No wheezes, rales, or rhonchi <input type="checkbox"/> Diminished breath sounds <input type="checkbox"/> Crackles present <input type="checkbox"/> Respiratory distress noted CV: <input type="checkbox"/> Regular rate and rhythm <input type="checkbox"/> No murmurs, rubs, or gallops <input type="checkbox"/> Peripheral pulses 2+ bilaterally <input type="checkbox"/> Edema present (1+ to 4+) <input type="checkbox"/> Capillary refill <2 sec <input type="checkbox"/> Jugular venous distention present MSK: <input type="checkbox"/> Normal range of motion <input type="checkbox"/> No joint swelling or tenderness <input type="checkbox"/> Muscle strength 5/5 bilaterally <input type="checkbox"/> Decreased strength in ____ <input type="checkbox"/> Gait normal <input type="checkbox"/> Antalgic gait <input type="checkbox"/> Joint effusion/swelling noted Neuro: <input type="checkbox"/> Alert & Oriented x4 <input type="checkbox"/> Normal motor and sensory function <input type="checkbox"/> Cranial nerves intact <input type="checkbox"/> Reflexes 2+ bilaterally <input type="checkbox"/> Decreased sensation in ____ <input type="checkbox"/> Positive Romberg test <input type="checkbox"/> Dysarthria noted <input type="checkbox"/> Tremors present Psych: <input type="checkbox"/> Normal mood and affect <input type="checkbox"/> Cooperative, appropriate behavior <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Flat affect <input type="checkbox"/> Agitated <input type="checkbox"/> Hallucinations/delusions noted	
A&P					
To do				Diagnostic tests (labs, x-rays, etc)	