

24 General Adult (5)

TIME SEEN: _____ ROOM: _____ EMS Arrival
PMD - Dr. _____
Referred by: Self PMD Dr. _____
HISTORIAN: patient spouse paramedics
____ HX / EXAM LIMITED BY: _____

Chief complaint: _____

Started: _____

pain at: 0 1 2 3 4 5 6 7 8 9 10

time course:	severity:	modifying factors:
<input type="checkbox"/> still present	<input type="checkbox"/> mild	<input type="checkbox"/> none
<input type="checkbox"/> better	<input type="checkbox"/> moderate	_____
<input type="checkbox"/> gone now	<input type="checkbox"/> severe	_____
<input type="checkbox"/> worse		_____

Similar symptoms previously _____

Recently seen / treated by doctor _____

ROS

CONST. fever
 subjective / to _____ °F
 chills

ENT sore throat
 nasal drainage / congestion

CVS / PULMONARY cough
 sputum
 trouble breathing
 chest pain

GI abdominal pain
 nausea / vomiting
 diarrhea
 black / bloody stools

URINARY problems urinating
 frequent urination

FEMALE GENITAL abnormal bleeding / discharge
GYN postmenopausal / hysterectomy
SKIN/MS skin rash
 back pain
 leg pain
 foot swelling
NEURO / EYES headache
 blackout
 loss feeling / power
 in arm / leg / face (R / L)
 difficulty walking
 difficulty with speech
 double vision
 confusion
 All systems neg, except as marked

PAST HX negative
 neurological problems lung disease
CVA seizure disorder asthma emphysema
 cardiac disease diabetes
heart attack (MI) angina insulin-dependent diet-controlled
heart failure oral hypoglycemic
 high blood pressure high cholesterol
 other problems

Influenza _____ Pneumococcal _____
Medications none see nurses note Allergies NKDA
ASA NSAID acetaminophen see nurses note
herbal / alternative medicines _____

SOCIAL HX _____
FAMILY HX _____

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Nursing Assessment Reviewed Vitals Reviewed

PHYSICAL EXAM Alert ___ Anxious ___ IV ___
General Appearance- Distress- ___no acute ___moderate ___severe

EENT scleral icterus / pale conjunctivae ___
eyes nml inspection purulent nasal drainage ___
ENT inspection nml pharyngeal erythema / exudate ___
pharynx nml

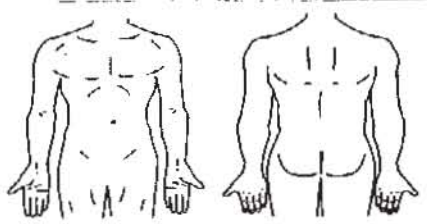
NECK thyromegaly ___
nml inspection lymphadenopathy (R / L) ___
thyroid nml

RESPIRATORY see diagram ___
no resp. distress wheezing ___
breath sounds nml rales ___
chest non-tender rhonchi ___

CVS irregularly irregular rhythm ___
regular rate, rhythm extrasystoles (occasional / frequent) ___
no murmur tachycardia / bradycardia ___
no gallop PMI displaced laterally ___
JVD present ___
murmur grade ___ / 6 sys / dias

gallop (S3 / S4) ___
friction rub ___
decreased pulse(s) ___
R carotid ___ fem ___ dors ped ___
L carotid ___ fem ___ dors ped ___

T=tenderness
R=rebound
m=mild
mod=moderate
sv=severe
Example: Tsv
indicates severe
tenderness.



ABDOMEN tenderness ___
non-tender guarding ___
no organomegaly rebound ___
nml bowel sounds abnormal bowel sounds ___
increased / decreased / absent
hepatomegaly / splenomegaly / mass ___

RECTAL black / bloody / hemepos / stool ___
non-tender tenderness / mass / module ___
heme neg stool

BACK CVA tenderness (R / L) ___
nml inspection

SKIN cyanosis / diaphoresis / pallor ___
color nml, no rash skin rash ___
warm, dry

EXTREMITIES pedal edema ___
non-tender calf tenderness ___
full ROM

NEURO / PSYCH disoriented to person / place / time ___
oriented x3 depressed affect ___
mood / affect nml facial droop / EOM palsy / anisocoria ___
CN's nml (2-12) weakness / sensory loss ___
no motor / sensory deficit

ABS, EKG, XRAYs and PROGRESS

CBC normal except WBC 12.1 Hgb 11.8 Hct 33.3 Platelets 250 Bands 0 lymphs 15 monos 10 eos 0	Chemistries normal except Na 135 K 3.8 Cl 105 CO2 24 BUN 14 crea 1.2 Gluc 112 Ca 10.0	CK 100 CKMB 10 Troponin 0.01 PT/PTT 13/35 Amylase 100 lipase 100	UA normal except WBC 10 RBC 10 protein
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EKG MONITOR STRIP NSR Rate 78
EKG NML Initiated by me Reviewed by me
NSR normal intervals 4 normal axis 1 nml QRS 1 normal ST/T

not / changed from
CXR Initiated by me Reviewed by me Discussed with physician
nml/NAD no infiltrates 1 nml heart size 1 nml disc / no masses
not / changed from

Time ___ unchanged ___ improved ___ re-examined
pain at ___
signed out to Dr. ___

Discussed with Dr. [Signature]
will see patient in office / ED / hospital
Counselor / patient / family regarding
lab results / progress / need for follow-up
Rx given Admit orders written
GRI CARE 10.7
75-104 mg
Prior records ordered
Additional history from
family / caretaker / paramedics

CLINICAL IMPRESSION:
DISPOSITION- home admitted transferred
CONDITION- unchanged improved stable
MD / DO: ___ ID# ___
PA: ___ ID# ___