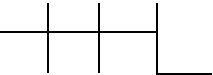


Name: Admit Date:		DOB/Age: Room #:						
ID: CC: DDx:								
HPI: Location: Onset: Characteristics: Associated Symptoms: Aggravations: Alleviated: Timing: Environment: Severity:								
PMH:  PSHx:  Prior Hosp:		FH:		SH: Lives with:  Occupation:  Relationship:  Travel: Pets:				
Meds: (Dose, frequency, route)		Allergies:		HRB: Tobacco: Alcohol: Drugs: Sex: Exercise:				
<b>General:</b> <input type="checkbox"/> Weight loss/pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever/chills <input type="checkbox"/> Changes in sleep <b>HEENT:</b> <input type="checkbox"/> HA <input type="checkbox"/> Hearing Changes <input type="checkbox"/> Vision changes <input type="checkbox"/> Vertigo <input type="checkbox"/> Congestion <input type="checkbox"/> Rhinorrhea <input type="checkbox"/> Sore Throat	<b>Cardio:</b> <input type="checkbox"/> Palpitations <input type="checkbox"/> Diaphoresis <input type="checkbox"/> Orthopnea <input type="checkbox"/> Edema <input type="checkbox"/> Claudication <input type="checkbox"/> Pain <b>Respiratory:</b> <input type="checkbox"/> Cough/sputum <input type="checkbox"/> Hemoptysis <input type="checkbox"/> SOB <input type="checkbox"/> Wheezing <input type="checkbox"/> Pleuritic pain	<b>GI:</b> <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Appetite changes <input type="checkbox"/> Bleeding <b>Skin:</b> <input type="checkbox"/> Rashes <input type="checkbox"/> Moles <input type="checkbox"/> Itching/dryness <input type="checkbox"/> Color Change	<b>GU:</b> <input type="checkbox"/> Pain w/ sex <input type="checkbox"/> D/c <input type="checkbox"/> Itching/rash <input type="checkbox"/> W: irregular menses <input type="checkbox"/> W: dysmenorrhea <input type="checkbox"/> M: hernia, testes problems <b>MSK:</b> <input type="checkbox"/> Muscle or joint pain/stiffness <input type="checkbox"/> Back pain <input type="checkbox"/> Swelling of joints	<b>Endocrine:</b> <input type="checkbox"/> Hot/cold intolerance <input type="checkbox"/> Sweating <input type="checkbox"/> Polyuria/polydipsia <input type="checkbox"/> Bleeding <b>Urinary:</b> <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Pain/burning <input type="checkbox"/> Hematuria <b>Psych:</b> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Memory loss	<b>Neurologic:</b> <input type="checkbox"/> Dizziness/fainting <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Tremor <input type="checkbox"/> Balance instability <b>ROS Additional Notes:</b>			
Physical Exam	BP:	Pulse:	RR:	Temp:	SaO2:	Weight:	Height:	BMI:
<b>General:</b> Alert and oriented. No acute distress. <b>HEENT:</b> Normocephalic, atraumatic. Pupils equal round and reactive. Normal conjunctiva. <b>Neck:</b> No JVD. Normal range of motion. <b>Cardiovascular:</b> Regular rate and rhythm. Normal S1, S2. No murmur, rub, or gallop. Intact peripheral pulses. <b>Pulmonary/chest:</b> No chest wall tenderness. Normal effort. Clear to auscultation bilaterally. No wheezes, rales, or rhonchi. <b>Abdominal:</b> Soft, nontender, nondistended. Normal bowel sounds. No guarding. <b>Musculoskeletal:</b> No edema. Full range of motion. <b>Neurological:</b> A & O x3. No focal neurologic deficits. <b>Skin:</b> Skin is warm and dry. No rashes. <b>Psychiatric:</b> Normal mood and affect.								
Labs:				Imaging:				
								
Assessment/Plan:								

