

Header Information

- I do not want a Header
- My Name
- My Company Name, Address and/or Logo
- Space for Patient Name, Date of Birth, Encounter Date
- Format_ (# Columns)** 1 2 3 4 5
- Maximum # Pages Desired** 1 2 3

Margin Information

- | | Top | Bottom | Left | Right |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1/2 inch | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3/4 inch | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1 inch | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| 1 3/4 inch | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 inch | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| > 2 inches, or other size (please specify) | | | | |

Allergies	Date	Start time	Stop time																				
<input type="checkbox"/> Allergy list reviewed <input type="checkbox"/> No drug allergies <input type="checkbox"/> No food allergies <input type="checkbox"/> Include prompters	Chief complaint/Reason for consult																						
Medications	History of Present Illness																						
<input type="checkbox"/> Medication list reviewed <input type="checkbox"/> Include prompters	<input type="checkbox"/> Include a list of prompter questions (that I specify later)																						
	History of <table border="0"> <tr> <td><input type="checkbox"/> Pleuritic chest pain present</td> <td><input type="checkbox"/> Recent mechanical ventilation *</td> </tr> <tr> <td><input type="checkbox"/> New or increased cough or dyspnea</td> <td><input type="checkbox"/> Recent severe emesis or esophageal dilatation</td> </tr> <tr> <td><input type="checkbox"/> New or increased peripheral edema</td> <td><input type="checkbox"/> MI or cardiothoracic surgery in prior month</td> </tr> <tr> <td><input type="checkbox"/> Orthopnea or paroxysmal nocturnal dyspnea</td> <td><input type="checkbox"/> COPD, CHF, DM, renal dysfunction, sickle cell</td> </tr> <tr> <td><input type="checkbox"/> Recent hematemesis or nose bleeds</td> <td><input type="checkbox"/> Malignancy or immunocompromised state *</td> </tr> <tr> <td><input type="checkbox"/> Recent fever, chills or nightsweats</td> <td><input type="checkbox"/> Neuromuscular weakness, scleroderma</td> </tr> <tr> <td><input type="checkbox"/> Taken antibiotics in past 6 months *</td> <td><input type="checkbox"/> Being primarily bedridden</td> </tr> <tr> <td><input type="checkbox"/> Patient is a nursing home resident *</td> <td><input type="checkbox"/> Alcohol, narcotic or benzodiazepine use</td> </tr> <tr> <td><input type="checkbox"/> Patient has been hospitalized in past 14 days*</td> <td><input type="checkbox"/> Recent exposure to children in daycare *</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Recent travel (consider SARS, Avian Influenza, endemic fungus, TB, etc.)</td> </tr> </table> <small>*(Consider atypical sources, S. pneumo, S. aureus, P. aeruginosa or drug resistant organisms)</small>			<input type="checkbox"/> Pleuritic chest pain present	<input type="checkbox"/> Recent mechanical ventilation *	<input type="checkbox"/> New or increased cough or dyspnea	<input type="checkbox"/> Recent severe emesis or esophageal dilatation	<input type="checkbox"/> New or increased peripheral edema	<input type="checkbox"/> MI or cardiothoracic surgery in prior month	<input type="checkbox"/> Orthopnea or paroxysmal nocturnal dyspnea	<input type="checkbox"/> COPD, CHF, DM, renal dysfunction, sickle cell	<input type="checkbox"/> Recent hematemesis or nose bleeds	<input type="checkbox"/> Malignancy or immunocompromised state *	<input type="checkbox"/> Recent fever, chills or nightsweats	<input type="checkbox"/> Neuromuscular weakness, scleroderma	<input type="checkbox"/> Taken antibiotics in past 6 months *	<input type="checkbox"/> Being primarily bedridden	<input type="checkbox"/> Patient is a nursing home resident *	<input type="checkbox"/> Alcohol, narcotic or benzodiazepine use	<input type="checkbox"/> Patient has been hospitalized in past 14 days*	<input type="checkbox"/> Recent exposure to children in daycare *		<input type="checkbox"/> Recent travel (consider SARS, Avian Influenza, endemic fungus, TB, etc.)
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Social History	Review of Systems																						
<input type="checkbox"/> Tobacco use _____ Packs x _____ Yrs <input type="checkbox"/> Quit <small>Daily, occasional and ex-smokers are more likely to be hazardous drinkers</small> <input type="checkbox"/> Alcohol use _____ Drinks per _____ day <input type="checkbox"/> week Hazardous drinking NIAAA (National Institute on Alcoholism and Alcohol Abuse guidelines) <small>Men > 14 drinks per week OR > 4 drinks per day</small> <small>Women > 7 drinks per week OR > 3 drinks per day</small> <input type="checkbox"/> Recreational drug use <input type="checkbox"/> Inhalational <input type="checkbox"/> Injectable <input type="checkbox"/> Ingestible <input type="checkbox"/> Drug dependence <input type="checkbox"/> Narcotics <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Leave blank for data entry <input type="checkbox"/> Include a list of prompters (i.e., marital status, drug & alcohol use, occupational history)	See HPI WNL <input type="checkbox"/> <input type="checkbox"/> Constitutional Fatigue, malaise, fever/chills, weight loss, change in appetite <input type="checkbox"/> <input type="checkbox"/> Eyes Vision changes, New pain, Scotomas <input type="checkbox"/> <input type="checkbox"/> ENT/mouth Nose bleeds, dental caries, dental abscesses, jaw pain <input type="checkbox"/> <input type="checkbox"/> Resp Dyspnea, Cough, Phlegm, Hemoptysis, Wheeze, Witnessed Apnea <input type="checkbox"/> <input type="checkbox"/> CV Chest pain, diaphoresis, ankle edema, PND, syncope <input type="checkbox"/> <input type="checkbox"/> GI Emesis, dysphagia, GERD, abdominal pain, diarrhea, melena <input type="checkbox"/> <input type="checkbox"/> GU Change in urinary habits, hematuria, dysuria <input type="checkbox"/> <input type="checkbox"/> Musc Myalgias, recent trauma, bony fractures, arthralgias, joint swelling <input type="checkbox"/> <input type="checkbox"/> Skin/breasts Rashes, new masses or skin lesions, increased sensitivity to sun <input type="checkbox"/> <input type="checkbox"/> Neuro Seizures, episodic or chronic muscle weakness <input type="checkbox"/> <input type="checkbox"/> Endo Hair loss, polydipsia <input type="checkbox"/> <input type="checkbox"/> Heme/lymph Bleeding gums, unusual bruising, swollen lymph nodes <input type="checkbox"/> <input type="checkbox"/> Allergy/Immun Sinus probs, recurrent infections <input type="checkbox"/> <input type="checkbox"/> Psych Mood changes, agitation, psychosis, delirium, dementia Occupational History <input type="checkbox"/> Include only a list of organ systems <input type="checkbox"/> Add a check box for "wnl" for "within normal limits" or "see HPI" <input type="checkbox"/> Include a list of prompter questions for each organ system <input type="checkbox"/> Use a standard set of prompter questions from Medical Templates <input type="checkbox"/> Use my questions listed as follows																						
Family Medical History	Past Medical and Surgical History																						
<input type="checkbox"/> Asthma <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> COPD <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Premature Onset <input type="checkbox"/> Malignancy <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Renal Dysfunction <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Leave blank for data entry <input type="checkbox"/> Include a list of prompters (i.e., CAD, Diabetes, CHF, COPD)	<input type="checkbox"/> Asthma <input type="checkbox"/> Cerebral Artery Disease <input type="checkbox"/> Neuromuscular weakness <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Occupational exposures <input type="checkbox"/> Colonoscopy <input type="checkbox"/> COPD <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Pancreatitis <input type="checkbox"/> ECHO/Stress Test <input type="checkbox"/> COP (BOOP) <input type="checkbox"/> Diabetes <input type="checkbox"/> Peripheral Artery Disease <input type="checkbox"/> Mammogram <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> GERD <input type="checkbox"/> Scleroderma <input type="checkbox"/> PFTs <input type="checkbox"/> Histiocytosis <input type="checkbox"/> Hepatic Dysfunction <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> PapSmear <input type="checkbox"/> Tuberculosis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Sjogren <input type="checkbox"/> Prior Intubations <input type="checkbox"/> PAH <input type="checkbox"/> Hypertension <input type="checkbox"/> Renal Dysfunction <input type="checkbox"/> Radiation exposure <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Inflam bowel disease <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Sleep Study <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Malignancy <input type="checkbox"/> Thrombotic Disease <input type="checkbox"/> Steroid use <input type="checkbox"/> Wegener's <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Obstructive Sleep Apnea <input type="checkbox"/> Leave blank for data entry <input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP <input type="checkbox"/> Include a list of prompters (i.e., CAD, Diabetes, CHF, COPD, PAD)																						
	Surgeries																						

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| 2 inch | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| > 2 inches, or other size (please specify) | | | | |

Vitals	Exam
<p>Specify vitals requested</p> <p><input type="checkbox"/> Weight</p> <p><input type="checkbox"/> BMI</p> <p><input type="checkbox"/> Temperature ★56</p> <p><input type="checkbox"/> BP ★56</p> <p><input type="checkbox"/> Pulse ★56</p> <p><input type="checkbox"/> Respiratory Rate ★56</p> <p><input type="checkbox"/> Sats ★57</p> <p><input type="checkbox"/> At Rest</p> <p><input type="checkbox"/> With Activity</p> <p><input type="checkbox"/> CVP</p> <p><input type="checkbox"/> Cardiac Output</p> <p><input type="checkbox"/> Urine Output</p> <p><input type="checkbox"/> Last 24 hours</p>	<p><input type="checkbox"/> Ventilator Settings Mode Rate Tidal Vol PEEP PS FIO2 PO2/FIO2 Plateau Pressure</p> <p><input type="checkbox"/> NonInvasive Ventilator (CPAP, BiPAP) Settings</p> <p>General <input type="checkbox"/> Alert</p> <p>ENT <input type="checkbox"/> Nasal mucosa <input type="checkbox"/> Dentition <input type="checkbox"/> Oropharynx Mallampati <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV</p> <p>Neck <input type="checkbox"/> Normal to palpation <input type="checkbox"/> Thyroid <input type="checkbox"/> No JVD</p> <p>Resp <input type="checkbox"/> Clear to auscultation <input type="checkbox"/> Dullness to percussion <input type="checkbox"/> No respiratory distress</p> <p><input type="checkbox"/> No chest wall defects <input type="checkbox"/> Decreased fremitus <input type="checkbox"/> Bronchial breath sounds</p> <p><input type="checkbox"/> Absence of intercostal respiratory retractions <input type="checkbox"/> Egophony (E to A change)</p> <p>CV <input type="checkbox"/> Clear S1 S2 <input type="checkbox"/> No murmur <input type="checkbox"/> No gallop <input type="checkbox"/> No rub <input type="checkbox"/> Peripheral pulses <input type="checkbox"/> No peripheral edema</p> <p>GI <input type="checkbox"/> No palpable masses <input type="checkbox"/> Liver and spleen not palpable <input type="checkbox"/> No hepatojugular reflux</p> <p>Lymph <input type="checkbox"/> No lymphadenopathy</p> <p>Musc <input type="checkbox"/> Tone <input type="checkbox"/> Gait</p> <p>Extrem <input type="checkbox"/> No clubbing <input type="checkbox"/> No cyanosis</p> <p>Skin <input type="checkbox"/> No rashes, ecchymoses, nodules, ulcers</p> <p>Neuro <input type="checkbox"/> Oriented ★58 (Pts with Community Acquired Bacterial Pneumonia) <input type="checkbox"/> Affect</p> <p style="text-align: center;">Glasgow Coma Score E ___ V ___ M ___ APACHE II Score ___</p> <p><input type="checkbox"/> Leave only a blank space for data entry</p> <p><input type="checkbox"/> Provide prompters for my field of specialty (i.e., FP, IM, Surgery, Dermatology)</p>
AHRQ Pneumonia Severity Index	Labs/Tests Impression and Plan
<p>Age</p> <p>Male Age (in years)</p> <p>Female Age (in years) - 10</p> <p>NH resident Age (in years) +10</p> <p>Comorbid illnesses</p> <p>Neoplastic disease +30</p> <p>Liver disease +20</p> <p>CHF +10</p> <p>Cerebrovascular disease +10</p> <p>Renal disease +10</p> <p>Physical exam findings</p> <p>Altered mental status +20</p> <p>Respiratory rate >= 30 +20</p> <p>Systolic BP < 90 +20</p> <p>Temp < 35 degrees or > 40 +15</p> <p>Pulse > 124 +10</p> <p>Lab Findings</p> <p>pH <7.35 +35</p> <p>BUN >10.7 mmol/L +20</p> <p>Sodium <130 mEq/L +20</p> <p>Glucose > 13.9 mmol/L +10</p> <p>Hematocrit <30 percent +10</p> <p>pO2 <60 mmHg +10</p> <p>Pleural effusion +10</p> <p>Risk Risk Class Based on</p> <p>Low I Algorithm</p> <p>Low II < 71 points</p> <p>Low III 71-90 points</p> <p>Moderate IV 91-130 points</p> <p>High V >130 points</p>	<p><input type="checkbox"/> Labs</p> <p><input type="checkbox"/> Leave only a blank space for data entry</p> <p><input type="checkbox"/> Provide "fishbone" for CBC and BMP</p> <p><input type="checkbox"/> CBC</p> <p><input type="checkbox"/> CMP <input type="checkbox"/> Leave only a blank space for data entry</p> <p><input type="checkbox"/> ABG <input type="checkbox"/> Leave space for 2 signatures</p> <p><input type="checkbox"/> Blood cultures - 2 sets <input type="checkbox"/> Add digital signature feature</p> <p><input type="checkbox"/> BNP</p> <p><input type="checkbox"/> Cardiac enzymes</p> <p><input type="checkbox"/> HIV</p> <p>Urinary antigen for</p> <p><input type="checkbox"/> Pneumococcus</p> <p><input type="checkbox"/> Legionella</p> <p><input type="checkbox"/> Histoplasma</p> <p>Nasopharyngeal wash for</p> <p><input type="checkbox"/> RSV, Influenza A, B, Parainfluenza</p> <p>Sputum cultures</p> <p><input type="checkbox"/> Gram stain and bacterial culture <input type="checkbox"/> Advanced Health Care Directives Information</p> <p><input type="checkbox"/> Fungal stain and culture <input type="checkbox"/> Leave only a blank space for data entry</p> <p><input type="checkbox"/> AFB stain and culture <input type="checkbox"/> Provide prompters for Name of HCPOA and Code Status</p> <p><input type="checkbox"/> Varicella zoster</p> <p><input type="checkbox"/> HSV</p> <p><input type="checkbox"/> Pneumocystis</p> <p><input type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> Legionella</p> <p><input type="checkbox"/> Tularemia</p> <p><input type="checkbox"/> Anthrax</p> <p><input type="checkbox"/> CXR (PA, lateral, lateral decubitus) Signature</p> <p><input type="checkbox"/> CT of chest Appropriate antibiotic selection ★59</p> <p><input type="checkbox"/> Patient has completed advanced health care directives ★47 HCPOA is</p> <p>Code Status <input type="checkbox"/> Patient is a FULL CODE <input type="checkbox"/> DO NOT ATTEMPT RESUSCITATION</p>

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1 1/2 inch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 3/4 inch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 inch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> 2 inches, or other size (please specify)				

Specify Changes Requested Here & List Specific Questions or Prompters