

<p><b>Date</b>  <b>Start Time</b>  <b>End Time</b></p> <p><b>Review of Systems</b>  <small>See HPI WNL</small></p> <p><input type="checkbox"/> <input type="checkbox"/> Constitutional  <input type="checkbox"/> <input type="checkbox"/> Eyes  <input type="checkbox"/> <input type="checkbox"/> ENT  <input type="checkbox"/> <input type="checkbox"/> Cardiovascular  <input type="checkbox"/> <input type="checkbox"/> Respiratory  <input type="checkbox"/> <input type="checkbox"/> Gastrointestinal  <input type="checkbox"/> <input type="checkbox"/> Genitourinary  <input type="checkbox"/> <input type="checkbox"/> Musculoskeletal  <input type="checkbox"/> <input type="checkbox"/> Skin  <input type="checkbox"/> <input type="checkbox"/> Neurologic  <input type="checkbox"/> <input type="checkbox"/> Endocrine  <input type="checkbox"/> <input type="checkbox"/> Psych  <input type="checkbox"/> <input type="checkbox"/> Heme/Lymph  <input type="checkbox"/> <input type="checkbox"/> Allergy/Immun</p> <p><b>Data Reviewed</b></p> <p><input type="checkbox"/> Past Medical History  <input type="checkbox"/> Social History  <input type="checkbox"/> Family Medical History  <input type="checkbox"/> Allergy list  <input type="checkbox"/> Medication list  <input type="checkbox"/> Labs/Tests  <input type="checkbox"/> ER Notes  <input type="checkbox"/> Old Chart  <input type="checkbox"/> EMS Note  <input type="checkbox"/> ECG  <input type="checkbox"/> Nursing Notes &amp; Vitals log  <input type="checkbox"/> Radiology studies</p> <p><b>Care coordinated with</b></p> <p><input type="checkbox"/> ER MD  <input type="checkbox"/> HCPOA  <input type="checkbox"/> PCP  <input type="checkbox"/> Case Mgmt or SW  <input type="checkbox"/> Pharmacy  <input type="checkbox"/> Nutrition team  <input type="checkbox"/> Physical therapy  <input type="checkbox"/> Respiratory therapy  <input type="checkbox"/> Nursing staff</p>	<p><b>Chief Complaint/Reason For Visit:</b>  <b>History of Present Illness:</b> <input type="checkbox"/> Patient is Nonverbal</p> <p><input type="checkbox"/> Oral intake appropriate <input type="checkbox"/> Moving bowels <input type="checkbox"/> Ambulating</p> <p><b>Physical Exam</b> <input type="checkbox"/> Check indicates findings are within normal limits</p> <p><b>Const</b> <input type="checkbox"/> <b>General</b></p> <p><b>Eye</b> <input type="checkbox"/> Conjunctivae <input type="checkbox"/> Pupils <input type="checkbox"/> Ears</p> <p><b>ENT</b> <input type="checkbox"/> TM <input type="checkbox"/> Pharynx <input type="checkbox"/> Dentition <input type="checkbox"/> Nasal <input type="checkbox"/> External ears <input type="checkbox"/> Hearing</p> <p><b>Neck</b> <input type="checkbox"/> Exam <input type="checkbox"/> Thyroid</p> <p><b>Resp</b> <input type="checkbox"/> Auscultation <input type="checkbox"/> Effort <input type="checkbox"/> Percussion <input type="checkbox"/> Palpation</p> <p><b>CV</b> <input type="checkbox"/> Ausc <input type="checkbox"/> Palp <input type="checkbox"/> Carotid <input type="checkbox"/> Aorta <input type="checkbox"/> Fem pulses <input type="checkbox"/> Pedal pulses</p> <p><b>Breasts</b> <input type="checkbox"/> Inspection <input type="checkbox"/> Palpation</p> <p><b>GI</b> <input type="checkbox"/> Abdomen <input type="checkbox"/> No hepatosplenomegaly <input type="checkbox"/> No hernias <input type="checkbox"/> Rectum <input type="checkbox"/> Guaiac</p> <p><b>GU</b> <input type="checkbox"/> Anus <input type="checkbox"/> Penis <input type="checkbox"/> Testes <input type="checkbox"/> Urethra</p> <p><b>Gyn</b> <input type="checkbox"/> External <input type="checkbox"/> Bladder <input type="checkbox"/> Cervix <input type="checkbox"/> Uterus <input type="checkbox"/> Adnexa</p> <p><b>Lymph</b> <input type="checkbox"/> Neck <input type="checkbox"/> Axilla <input type="checkbox"/> Groin <input type="checkbox"/> Other</p> <p><b>Musc</b> <input type="checkbox"/> Gait <input type="checkbox"/> DTR <input type="checkbox"/> Inspection <input type="checkbox"/> ROM <input type="checkbox"/> Stability <input type="checkbox"/> Strength</p> <p><b>Skin</b> <input type="checkbox"/> Inspection <input type="checkbox"/> Palpation</p> <p><b>Neuro</b> <input type="checkbox"/> CN <input type="checkbox"/> DTR <input type="checkbox"/> Sensation</p> <p><b>Psych</b> <input type="checkbox"/> Affect <input type="checkbox"/> Orientation <input type="checkbox"/> Insight <input type="checkbox"/> Memory</p> <p><b>Impression/Plan</b></p> <p>Signature _____</p> <p>CODE STATUS: <input type="checkbox"/> Full code <input type="checkbox"/> Do Not Attempt Resuscitation</p>	<p><b>Vitals</b></p> <p>Wt  Temp  Pulse  Resp  BP</p> <p><b>IV Medications:</b></p> <p><input type="checkbox"/> Antiarrhythmics  <input type="checkbox"/> Antibiotics  <input type="checkbox"/> Antihypertensives  <input type="checkbox"/> Benzodiazepines  <input type="checkbox"/> Diuretics  <input type="checkbox"/> Heparin  <input type="checkbox"/> Insulin  <input type="checkbox"/> Narcotics  <input type="checkbox"/> Pressors  <input type="checkbox"/> Sedation  <input type="checkbox"/> Steroids  <input type="checkbox"/> Thrombolytic  <input type="checkbox"/> TPN</p> <p><b>Labs</b></p> <p><b>This patient receiving</b></p> <p><input type="checkbox"/> Aggressive pulm toilet  <input type="checkbox"/> DVT prophylaxis  <input type="checkbox"/> Stress ulcer prophylaxis  <input type="checkbox"/> Daily sedation vacation  <input type="checkbox"/> Head of bed elev &gt; 30°  <input type="checkbox"/> Intense glycemic control  <input type="checkbox"/> Changing central lines  <input type="checkbox"/> Physical therapy  <input type="checkbox"/> Swallow evaluation  <input type="checkbox"/> Pneumo vac before d/c  <input type="checkbox"/> Flu vac before d/c</p>
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