

<input type="checkbox"/> Patient is nonverbal or otherwise unable to provide history. Information obtained from _____		Consultants
Referring Physician Reason for Consult/Chief Complaint History of Present Illness 		

Review of Systems <small>See HPI WNL</small> <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 <input type="checkbox"/> <input type="checkbox"/> Resp Dyspnea, Cough, Phlegm, Hemoptysis, Wheezing <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 tenderness <input type="checkbox"/> <input type="checkbox"/> Skin/breasts Rashes, nonhealing areas, new moles <input type="checkbox"/> <input type="checkbox"/> Neuro New paresthesias, gait abnormality, seizure, muscle weakness <input type="checkbox"/> <input type="checkbox"/> Endo Hair loss, polydipsia <input type="checkbox"/> <input type="checkbox"/> Heme/lymph Bleeding gums, unexplained 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	Allergies <input type="checkbox"/> Allergy list reviewed <input type="checkbox"/> No drug allergies <input type="checkbox"/> No food allergies
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Past Medical and Social History <input type="checkbox"/> Asthma <input type="checkbox"/> Cerebral Vascular Disease <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> COPD <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Hepatic Dysfunction <input type="checkbox"/> Hypertension <input type="checkbox"/> Obstructive Sleep Apnea <input type="checkbox"/> Tobacco _____ Packs x _____ Yrs <input type="checkbox"/> Quit <input type="checkbox"/> Alcohol <input type="checkbox"/> Recreational drugs <input type="checkbox"/> Vaccines <input type="checkbox"/> Tetanus <input type="checkbox"/> Pertussis	<input type="checkbox"/> Malignancy <input type="checkbox"/> Neuromuscular weakness <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Renal Dysfunction <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Thrombotic Disease <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Chronic Kidney Disease	<input type="checkbox"/> Prior Intubations <input type="checkbox"/> Steroid use <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation Exposure <input type="checkbox"/> Autoimmune disease <input type="checkbox"/> Occupational exposures <input type="checkbox"/> PFTs <input type="checkbox"/> ECHO/Stress Test <input type="checkbox"/> Sleep Study	<input type="checkbox"/> Colonoscopy <input type="checkbox"/> Mammogram <input type="checkbox"/> PapSmear
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Surgeries 	Family Medical History <input type="checkbox"/> Asthma <input type="checkbox"/> Cerebral Vascular Disease <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> COPD <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Hepatic Dysfunction <input type="checkbox"/> Hypertension <input type="checkbox"/> Malignancy <input type="checkbox"/> Neuromuscular Disease <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Periph Vascular Dis <input type="checkbox"/> Renal Dysfunction <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Thrombotic Disorder <input type="checkbox"/> Thyroid Disease
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Exam		<input type="checkbox"/> Checked box indicates findings are within normal limits
T P R BP Wt Pulse ox	General	<input type="checkbox"/> Alert
	Eye	<input type="checkbox"/> Conjunctivae <input type="checkbox"/> Pupils <input type="checkbox"/> Discs
	ENT	<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
	Neck	<input type="checkbox"/> Exam <input type="checkbox"/> Thyroid
	Resp	<input type="checkbox"/> Clear to auscultation <input type="checkbox"/> Clear to percussion <input type="checkbox"/> Effort <input type="checkbox"/> Normal to palpation
	CV	<input type="checkbox"/> Auscultation <input type="checkbox"/> Palpation <input type="checkbox"/> Edema <input type="checkbox"/> Carotids <input type="checkbox"/> Aorta <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Pedal pulses
	GI	<input type="checkbox"/> Abdomen <input type="checkbox"/> No hepatosplenomegaly <input type="checkbox"/> No hernias <input type="checkbox"/> Rectum <input type="checkbox"/> Guaiac
	Breasts	<input type="checkbox"/> Inspection <input type="checkbox"/> Palpation
	GU	<input type="checkbox"/> Scrotum <input type="checkbox"/> Penis <input type="checkbox"/> Prostate <input type="checkbox"/> Urethra
	Gyn	<input type="checkbox"/> External <input type="checkbox"/> Bladder <input type="checkbox"/> Cervix <input type="checkbox"/> Uterus <input type="checkbox"/> Adnexa
	Lymph	<input type="checkbox"/> Neck <input type="checkbox"/> Axilla <input type="checkbox"/> Groin <input type="checkbox"/> Other
	Musc	<input type="checkbox"/> Gait <input type="checkbox"/> Digit <input type="checkbox"/> Inspection <input type="checkbox"/> ROM <input type="checkbox"/> Stability <input type="checkbox"/> Strength
	Skin	<input type="checkbox"/> Inspection <input type="checkbox"/> Palpation
	Neuro	<input type="checkbox"/> CN <input type="checkbox"/> DTR <input type="checkbox"/> Sensation
	Psych	<input type="checkbox"/> Affect <input type="checkbox"/> Orientation <input type="checkbox"/> Insight <input type="checkbox"/> Judgment

Labs/Tests Impression/Plan

Schedule

- Influenza vaccine
- Pneumococcal vaccine
- Colonoscopy
- Mammogram
- Cardiac Stress Test
- Echocardiogram
- Other

Labs

Consult

Follow Up

Signature/Date: _____

CODE STATUS: Full code Do Not Attempt Resuscitation

Data Reviewed: ER Notes Old Chart Nursing Notes & Vitals log Labs Radiology data ECHO ECG Stress Test PFT Diabetic log

Coordination of care: Discuss w/HCP/POA Discuss w/Social Worker