

Hospital Followup Note

<b>Date</b>	<b>Chief Complaint/Reason For Visit</b>	<b>Start time</b> <b>Stop time</b>
<b>Review of Systems</b>	<b>History of Present Illness</b> <input type="checkbox"/> Patient is Nonverbal	<b>Vitals</b>
See HPI WNL <input type="checkbox"/> Constitutional <input type="checkbox"/> Eyes <input type="checkbox"/> ENT <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Respiratory <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Genitourinary <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Neurologic <input type="checkbox"/> Endocrine <input type="checkbox"/> Psych <input type="checkbox"/> Heme/Lymph <input type="checkbox"/> Allergy/Immun	<input type="checkbox"/> Oral intake appropriate <input type="checkbox"/> Moving bowels <input type="checkbox"/> Cough <input type="checkbox"/> Sputum <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Dyspnea <input type="checkbox"/> Chest pain <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Hematuria <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Nocturia <input type="checkbox"/> Urinary retention <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Anorexia <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Insomnia <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Alcohol use <input type="checkbox"/> Tobacco use <input type="checkbox"/> Drug use <input type="checkbox"/> Recent falls	Wt BMI  Temp Pulse  Resp O <sub>2</sub>  BP CVP  Input/Output 24 hr
<b>Data Reviewed</b>	<b>Physical Exam</b> <input type="checkbox"/> Check indicates findings are within normal limits	<b>IV Medications</b>
<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 & Vitals log <input type="checkbox"/> Radiology studies	<b>Const</b> <input type="checkbox"/> General <b>Eye</b> <input type="checkbox"/> Conjunctivae <input type="checkbox"/> Pupils <input type="checkbox"/> Discs <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 <b>Neck</b> <input type="checkbox"/> Exam <input type="checkbox"/> Thyroid <b>Resp</b> <input type="checkbox"/> Auscultation <input type="checkbox"/> Effort <input type="checkbox"/> Retraction <input type="checkbox"/> Position <b>CV</b> <input type="checkbox"/> JVP <input type="checkbox"/> Murmurs <input type="checkbox"/> Edema <input type="checkbox"/> Rales <input type="checkbox"/> Crackles <input type="checkbox"/> S3 <input type="checkbox"/> S4 <input type="checkbox"/> Peripheral pulses <input type="checkbox"/> Pedal pulses <b>GI</b> <input type="checkbox"/> Abdomen <input type="checkbox"/> Hepatosplenomegaly <input type="checkbox"/> No hernias <input type="checkbox"/> Rectum <input type="checkbox"/> Guaiac <b>GU</b> <input type="checkbox"/> Scrotum <input type="checkbox"/> Penis <input type="checkbox"/> Prostate <input type="checkbox"/> Urethra <b>Lymph</b> <input type="checkbox"/> Neck <input type="checkbox"/> Axilla <input type="checkbox"/> Groin <input type="checkbox"/> Other <b>Musc</b> <input type="checkbox"/> Gait <input type="checkbox"/> Digit <input type="checkbox"/> Reflexion <input type="checkbox"/> Stability <input type="checkbox"/> Strength <b>Skin</b> <input type="checkbox"/> Inspection <input type="checkbox"/> Palpation <b>Neuro</b> <input type="checkbox"/> Gait <input type="checkbox"/> Reflexion <input type="checkbox"/> Sensation <b>Psych</b> <input type="checkbox"/> Affect <input type="checkbox"/> Orientation <input type="checkbox"/> Insight <input type="checkbox"/> Memory	<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
<b>Care coordinated with</b>	<b>Impression</b>	<b>Plan</b>
<input type="checkbox"/> ER MD <input type="checkbox"/> HCPOA <input type="checkbox"/> PCP <input type="checkbox"/> Case Management <input type="checkbox"/> Social Worker <input type="checkbox"/> Pharmacy <input type="checkbox"/> Nutrition team <input type="checkbox"/> Physical therapy <input type="checkbox"/> Respiratory therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Nursing staff	Signature <input type="checkbox"/> Patient has completed advanced health care directives★47 HCPOA is Code Status <input type="checkbox"/> Patient is a FULL CODE <input type="checkbox"/> DO NOT ATTEMPT RESUSCITATION	<input type="checkbox"/> Labs <input type="checkbox"/> Cultures <input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> Urine <input type="checkbox"/> Radiographs <input type="checkbox"/> Cardiac Stress Testing <input type="checkbox"/> ECHO <input type="checkbox"/> PFTs <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 > 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