

Pneumonia Evaluation

MRN	Date	Start time	Stop time
Allergies	Chief complaint/Reason for consult		
Medications	History of Present Illness		
	<p>History of Present Illness</p> <p><input type="checkbox"/> Pleuritic chest pain present</p> <p><input type="checkbox"/> New or increased cough or dyspnea</p> <p><input type="checkbox"/> New or increased peripheral edema</p> <p><input type="checkbox"/> Orthopnea or paroxysmal nocturnal dyspnea</p> <p><input type="checkbox"/> Recent hematemesis or nose bleeds</p> <p><input type="checkbox"/> Recent fever, chills or night sweats</p> <p><input type="checkbox"/> Taken antibiotics in past 6 months</p> <p><input type="checkbox"/> Patient is a nursing home resident</p> <p><input type="checkbox"/> Patient has been hospitalized in past 30 days*</p> <p><input type="checkbox"/> Recent severe emesis or esophageal intubation</p> <p><input type="checkbox"/> MI or thoracic surgery in prior month</p> <p><input type="checkbox"/> COPD, CHF, DM, renal dysfunction, sickle cell</p> <p><input type="checkbox"/> Pregnancy, immunocompromised state *</p> <p><input type="checkbox"/> Neuromuscular weakness, skin disorders</p> <p><input type="checkbox"/> Being primarily bedridden</p> <p><input type="checkbox"/> Alcohol, narcotic or benzodiazepine use</p> <p><input type="checkbox"/> Recent exposure to children in daycare *</p> <p><input type="checkbox"/> Recent mechanical ventilation *</p> <p><small>*(Consider atypical sources, S. pneumoniae, S. aureus, P. aeruginosa or drug resistant organisms)</small></p>		
Social History	Review of Systems		
<p><input type="checkbox"/> Tobacco use</p> <p>____ Packs x ____ Yrs <input type="checkbox"/> Quit</p> <p><i>Daily, occasional and ex-smokers are more likely to be hazardous drinkers</i></p> <p><input type="checkbox"/> Alcohol use</p> <p>____ Drinks per _____</p> <p><input type="checkbox"/> day <input type="checkbox"/> week</p> <p>Hazardous drinking</p> <p>NIAAA (National Institute on Alcoholism and Alcohol Abuse guidelines)</p> <p>Men > 14 drinks per week OR > 4 drinks per day</p> <p>Women > 7 drinks per week OR > 3 drinks per day</p> <p><input type="checkbox"/> Recreational drug use</p> <p><input type="checkbox"/> Inhalational <input type="checkbox"/> Injected <input type="checkbox"/> Ingestible</p> <p><input type="checkbox"/> Drug dependence</p> <p><input type="checkbox"/> Narcotics <input type="checkbox"/> Benzodiazepines</p>	<p>See HPI WNL</p> <p><input type="checkbox"/> Constitutional Fever, chills, weight loss, change in appetite</p> <p><input type="checkbox"/> E Vision changes, eye pain, Scotomas</p> <p><input type="checkbox"/> ENT Nose bleeds, dental caries, dental abscesses, jaw pain</p> <p><input type="checkbox"/> Resp Cough, Phlegm, Hemoptysis, Wheeze, Witnessed Apnea</p> <p><input type="checkbox"/> CV Chest pain, edema, ankle edema, PND, syncope</p> <p><input type="checkbox"/> GI Emesis, dysphagia, GERD, abdominal pain, diarrhea, melena</p> <p><input type="checkbox"/> GU Change in urinary habits, hematuria, dysuria</p> <p><input type="checkbox"/> Musculoskeletal Myalgias, recent trauma, bony fractures, arthralgias, joint swelling</p> <p><input type="checkbox"/> Skin Rash, new masses or skin lesions, increased sensitivity to sun</p> <p><input type="checkbox"/> Neuro Seizures, episodic or chronic muscle weakness</p> <p><input type="checkbox"/> Endocrine Hair loss, polydipsia</p> <p><input type="checkbox"/> Heme/lymph Bleeding gums, unusual bruising, swollen lymph nodes</p> <p><input type="checkbox"/> Allergy/Immun Sinus probs, recurrent infections</p> <p><input type="checkbox"/> Psych Mood changes, agitation, psychosis, delirium, dementia</p> <p>Occupational History</p>		
Family Medical History	Past Medical and Surgical History		
<p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Congestive Heart Failure</p> <p><input type="checkbox"/> COPD</p> <p><input type="checkbox"/> Coronary Artery Disease</p> <p><input type="checkbox"/> Premature Onset</p> <p><input type="checkbox"/> Malignancy</p> <p><input type="checkbox"/> Pancreatitis</p> <p><input type="checkbox"/> Peripheral Vascular Disease</p> <p><input type="checkbox"/> Renal Dysfunction</p> <p><input type="checkbox"/> Thyroid Disease</p>	<p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Cerebral Artery Disease</p> <p><input type="checkbox"/> Congestive Heart Failure</p> <p><input type="checkbox"/> COPD</p> <p><input type="checkbox"/> Coronary Artery Disease</p> <p><input type="checkbox"/> COP (BOOP)</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Cystic Fibrosis</p> <p><input type="checkbox"/> GERD</p> <p><input type="checkbox"/> Histoplasmosis</p> <p><input type="checkbox"/> Hepatic Dysfunction</p> <p><input type="checkbox"/> HIV/AIDS</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Inflamm bowel disease</p> <p><input type="checkbox"/> Malignancy</p> <p><input type="checkbox"/> Wegener's</p> <p><input type="checkbox"/> Obstructive Sleep Apnea</p> <p><input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP</p> <p>Surgeries</p> <p><input type="checkbox"/> Neuromuscular weakness</p> <p><input type="checkbox"/> Occupational exposures</p> <p><input type="checkbox"/> Pancreatitis</p> <p><input type="checkbox"/> Peripheral Artery Disease</p> <p><input type="checkbox"/> Scleroderma</p> <p><input type="checkbox"/> Seizure Disorder</p> <p><input type="checkbox"/> Sinusitis</p> <p><input type="checkbox"/> Renal Dysfunction</p> <p><input type="checkbox"/> Rheumatoid arthritis</p> <p><input type="checkbox"/> Thrombotic Disease</p> <p><input type="checkbox"/> Thyroid Disease</p> <p><input type="checkbox"/> Chemotherapy</p> <p><input type="checkbox"/> Colonoscopy</p> <p><input type="checkbox"/> ECHO/Stress Test</p> <p><input type="checkbox"/> Mammogram</p> <p><input type="checkbox"/> PFTs</p> <p><input type="checkbox"/> PapSmear</p> <p><input type="checkbox"/> Prior Intubations</p> <p><input type="checkbox"/> Radiation exposure</p> <p><input type="checkbox"/> Sleep Study</p> <p><input type="checkbox"/> Steroid use</p>		

Pneumonia Evaluation

Vitals	Exam
Weight BMI Temperature BP Pulse Sats At Rest With Activity CVP Cardiac Output Urine Output Last 24 hours Last 8 hours	Exam Ventilator Settings Mode _____ Rate _____ Tidal Vol _____ PEEP _____ PS _____ FIO2 _____ PO2/FIO2 _____ Plateau Pressure _____ NonInvasive Ventilator (CPAP, BiPAP) Settings General <input type="checkbox"/> Alert ENT <input type="checkbox"/> Nasal mucosa <input type="checkbox"/> Dentition <input type="checkbox"/> Oropharynx Mallampatti <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV Neck <input type="checkbox"/> Normal to palpation <input type="checkbox"/> Thyroid <input type="checkbox"/> No JVD Resp <input type="checkbox"/> Clear to auscultation <input type="checkbox"/> Dullness to percussion <input type="checkbox"/> No respiratory distress <input type="checkbox"/> No chest wall defects <input type="checkbox"/> Decreased fremitus <input type="checkbox"/> Bronchial breath sounds <input type="checkbox"/> Absence of intercostal respiratory retractions <input type="checkbox"/> Egophony (E to A change) CV <input type="checkbox"/> No rales <input type="checkbox"/> No crackles <input type="checkbox"/> No gallop <input type="checkbox"/> No JVP <input type="checkbox"/> No peripheral edema GI <input type="checkbox"/> No palpable masses <input type="checkbox"/> Liver and spleen not palpable <input type="checkbox"/> No hepatjugular Lymph <input type="checkbox"/> No lymphadenopathy Musc <input type="checkbox"/> Tone <input type="checkbox"/> Gait Extrem <input type="checkbox"/> No clubbing <input type="checkbox"/> No cyanosis Skin <input type="checkbox"/> No rashes, ecchymoses, nodules, ulcers Neuro <input type="checkbox"/> Oriented ☆ 58 (Pt. with Community Acquired Bacterial Pneumonia) <input type="checkbox"/> Affect Glasgow Coma Score E _____ V _____ M _____ APACHE II Score _____
PORT Severity Index	Labs/Tests Impression and Plan
Age Male Age (in years) Female Age (in years) - 10 NH resident Age (in years) +10 Comorbid illnesses Neoplastic disease +30 Liver disease +20 CHF +10 Cerebrovascular disease +10 Renal disease +10 Physical exam findings Altered mental status +20 Respiratory rate >= 30 +20 Systolic BP < 90 +20 Temp < 35 degrees or > 40 +15 Pulse > 124 +10 Lab Findings pH < 7.35 +35 BUN > 10.7 mmol/L +20 Sodium < 130 mEq/L +20 Glucose > 13.9 mmol/L +10 Hematocrit < 30 percent +10 pO2 < 60 mmHg +10 Pleural effusion +10 Risk Risk Class Based on Low I Algorithm Low II < 71 points Low III 71-90 points Moderate IV 91-130 points High V >130 points	Labs/Tests <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> ABG <input type="checkbox"/> Blood cultures - 2 sets <input type="checkbox"/> Urine <input type="checkbox"/> Cardiac enzymes <input type="checkbox"/> Papanicolaou Urine specimen for <input type="checkbox"/> Pneumococcus <input type="checkbox"/> Legionella <input type="checkbox"/> Histoplasma Nasopharyngeal wash for <input type="checkbox"/> RSV <input type="checkbox"/> Influenza A, B, Parainfluenza Sputum cultures <input type="checkbox"/> Gram stain and bacterial culture <input type="checkbox"/> Fungal stain and culture <input type="checkbox"/> AFB stain and culture <input type="checkbox"/> Varicella zoster <input type="checkbox"/> HSV <input type="checkbox"/> Pneumocystis <input type="checkbox"/> Histoplasma <input type="checkbox"/> Legionella <input type="checkbox"/> CXR (PA, lateral, lateral decubitus) <input type="checkbox"/> CT of chest 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