Patient _____ Gender _____ Age _____ Doctor _____

Diagnosis _____

Diet: _____

Lab: _____

Other tests: _____

Treatments: _____

IV Orders: _____

MEDICATION ORDERS: ALLERGIES: _____

Diabetes: Type I Insulin: _____ Type II Medication: _____

Blood sugar _____ Blood sugar _____ Blood sugar_____

	Medication/dose/route/frequency	reason for giving	Time(s) to give		
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

CHIEF COMPLAINT/PRESENT ILLNESS (why the patient is here)	
HISTORY (past illness, injuries, hospitalizations, surgery, sleep patterns, family)	
GENERAL: Normal Weight _____ B/P_____ Pulse_____ Respirations_____ Temperature_____	
SKIN (rashes, itching, hives, bruising, eczema, dryness, skin color changes, hair texture changes, nail texture changes, appearance of nails (including toes), previous skin disorders, lumps, use of hair dyes)	
EYES, NOSE, EARS (eyeglasses, redness, problems with vision, eye discharge, glaucoma, cataracts, last eye exam, eye injuries, nasal discharge, nosebleeds, sinus infections, hay fever, nasal obstruction, frequency of colds, hearing aid, hard of hearing, deafness, ringing in ears, dizziness, ear discharge, pain in ears)	PERRLA_____
MOUTH AND THROAT (condition of teeth and gums, bad breath, problems with chewing or eating, last dental exam, frequency of sore throats, changes in voice, persistent hoarseness, thyroid problems, goiter, lumps, pain in neck, swollen glands)	
BREAST (lumps, discharge, pain, frequency of self exam)	
CARDIOVASCULAR (chest pain, palpitations, murmurs, high blood pressure, shortness of breath with exertion or lying down, history of heart attack or rheumatic fever, varicose veins, pain in legs or calves with walking, swelling in legs or feet, coolness of an extremity, loss of hair on legs, discoloration of an extremity, ulcers)	HR regular irregular _____ S_3 ___ S_4 ___ murmur ____
RESPIRATORY (cough, wheezing, sputum amount and color, bloody sputum, shortness of breath, asthma, pleurisy, bronchitis, TB, last chest X-ray, last TB skin test)	Pulse Ox____ O_2____
GASTROINTESTINAL (recent weight loss, appetite, heartburn, belching, nausea, vomiting, abdominal pain, constipation, change in color or consistency of stool, frequency of stool, hemorrhoids, rectal bleeding, use of laxatives, jaundice, hepatitis, gallbladder problems)	flat/round/distended bowel sounds? yes no Pain location→
GENITOURINARY (color and odor of urine, frequency, urgency, difficulty starting stream, stress incontinence, excessive, painful or burning urination, blood in urine, flank pain, waking at night to urinate, retention, kidney stones, UTIs, STDs, MALES→prostate problems, self exam of testicles, FEMALES→onset of menses, frequency and length of periods, date of menopause, pregnancies/miscarriages, use of birth control, date of last PAP)	Last BM_____
MUSCULOSKELETAL (pain or stiffness in joints, weakness, deformities, limitations in ability to ambulate and transfer, joint clicking, muscle cramps or spasms, use of assistive devices, use of prosthesis, problems with balance, history of gout, arthritis, bursitis or fractures, ability to carry out ADLs)	
NEUROLOGICAL (headache, fainting, dizziness, ataxia, blackouts, paralysis, numbness, tingling, burning, tremors, memory loss, mood changes, nervousness, speech problems, loss of consciousness, hallucinations, visual disturbances, disorientation, history of brain injury or stroke)	Orientation Hand grips? L R Facial symmetry

DISCHARGE PLAN: _____