

Patient Stamp

Comprehensive Review of Systems

ROS NOT OBTAINABLE BECAUSE

<p><u>Constitutional:</u></p> <table><thead><tr><th>YES</th><th>NO</th><th>DESCRIBE</th></tr></thead><tbody><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fever, sweats or chills</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fatigue, anorexia, weight loss or gain</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Weakness</td></tr></tbody></table>	YES	NO	DESCRIBE	<input type="checkbox"/>	<input type="checkbox"/>	Fever, sweats or chills	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue, anorexia, weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<p><u>Genitourinary:</u></p> <table><thead><tr><th>YES</th><th>NO</th><th>DESCRIBE</th></tr></thead><tbody><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Dysuria, frequency or urgency</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Menstrual irregularities</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>LMP _____</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Frequent UTI's</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pain/Hematuria</td></tr></tbody></table>	YES	NO	DESCRIBE	<input type="checkbox"/>	<input type="checkbox"/>	Dysuria, frequency or urgency	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual irregularities	<input type="checkbox"/>	<input type="checkbox"/>	LMP _____	<input type="checkbox"/>	<input type="checkbox"/>	Frequent UTI's	<input type="checkbox"/>	<input type="checkbox"/>	Pain/Hematuria
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<p><u>Skin:</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Rashes, no skin breakdown</p>	<p><u>Musculoskeletal:</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Muscle aches, arthralgias or arthritis</p>																														
<p><u>Head:</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Headache</p> <p><input type="checkbox"/> <input type="checkbox"/> Visual changes</p> <p><input type="checkbox"/> <input type="checkbox"/> Earache, sinus problems, sore throat</p> <p><input type="checkbox"/> <input type="checkbox"/> Cough, snoring or mouth ulcers</p>	<p><u>Neurologic:</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Mental status changes</p> <p><input type="checkbox"/> <input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Weakness or numbness</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Ataxia</p>																														
<p><u>Cardiovascular:</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Chest pain or palpitations</p> <p><input type="checkbox"/> <input type="checkbox"/> Syncope</p> <p><input type="checkbox"/> <input type="checkbox"/> Edema</p>	<p><u>Hematopoietic:</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Lymphadenopathy</p> <p><input type="checkbox"/> <input type="checkbox"/> Bleeding tendencies</p>																														
<p><u>Respiratory:</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> <input type="checkbox"/> Cough or sputum production</p> <p><input type="checkbox"/> <input type="checkbox"/> Dyspnea on exertion orthopnea</p> <p><input type="checkbox"/> <input type="checkbox"/> Pleuritic chest pain</p>	<p><u>Psychiatric:</u></p> <p><input type="checkbox"/> <input type="checkbox"/> History of anxiety or depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Hallucinations/Delusions</p>																														
<p><u>Gastrointestinal:</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Heartburn, dysphagia</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea or vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea or constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Melena or BRBPR</p> <p><input type="checkbox"/> <input type="checkbox"/> Hematemesis</p> <p><input type="checkbox"/> <input type="checkbox"/> Abdominal pain</p>	<p><u>Endocrine:</u></p> <p><input type="checkbox"/> <input type="checkbox"/> History of diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> History of thyroid problems</p>																														
	<p><u>Other Symptoms:</u></p>																														

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Physical Exam

Labs and Studies

<p><u>Vitals:</u> Wt: Temp: BP: P: HT: Resp: Sat:</p>	<p><u>CBC:</u></p>
<p><u>Constitutional:</u> <input type="checkbox"/> nl general appearance</p>	
<p><u>Head:</u> <input type="checkbox"/> Normo-cephalic/atramatic <input type="checkbox"/> PERRLA <input type="checkbox"/> EOMI <input type="checkbox"/> nl sclera <input type="checkbox"/> Vision</p>	<p><u>BMP:</u></p>
<p><u>Ears, Nose, Mouth & Throat:</u> <input type="checkbox"/> nl inspection of nasal mucosa, septum, turbinates, teeth, gums & oropharynx <input type="checkbox"/> nl ear canal and T</p>	<p><u>CXR:</u></p>
<p><u>Neck:</u> <input type="checkbox"/> nl neck appearance & jugular veins <input type="checkbox"/> Thyroid not palpable, non-tender</p>	<p><u>EKG:</u></p>
<p><u>Lymph Nodes</u> <input type="checkbox"/> nl neck, supraclavicular or axillary adenopathy</p>	
<p><u>Skin/Extremities:</u> <input type="checkbox"/> Rashes, lesions or ulcers <input type="checkbox"/> Digits & nails <input type="checkbox"/> Edema</p>	
<p><u>Breast Evaluation:</u> <input type="checkbox"/> No skin changes <input type="checkbox"/> No nipple discharge <input type="checkbox"/> No lumps/masses <input type="checkbox"/> Fibrocystic changes</p>	
<p><u>Respiratory:</u> <input type="checkbox"/> Chest symmetric, nl chest Expansion & respiratory effort <input type="checkbox"/> nl auscultation <input type="checkbox"/> nl chest percussion & palpation</p>	
<p><u>Cardiovascular:</u> <input type="checkbox"/> Reg rhythm <input type="checkbox"/> No murmur, gallop or rub <input type="checkbox"/> Periph vasc no by ovserv & palpation</p>	
<p><u>Gastrointestinal:</u> <input type="checkbox"/> No tenderness or masses <input type="checkbox"/> Liver & spleen not felt <input type="checkbox"/> nl bowel sounds <input type="checkbox"/> Heme negative stool</p>	
<p><u>Musculoskeletal:</u> <input type="checkbox"/> nl muscle strength, movement & tone, no focal atrophy <input type="checkbox"/> nl gait & station</p>	<p><u>Neurologic:</u> <input type="checkbox"/> Alert and oriented <input type="checkbox"/> nl reflexes upper and lower extremities <input type="checkbox"/> Cranial nerves intact</p>
<p><u>Genito-urinary:</u> <input type="checkbox"/> no pelvic exam <input type="checkbox"/> nl testes</p>	<p><u>Psychiatric:</u> <input type="checkbox"/> nl mood/affect</p>

Patient Stamp

Assessment:

Plan:

Attending HPI:

Attending PE:

Attending Assessment and Plan:

Resident signature: _____ MD PGY1, PGY2, PGY3 Date: _____ Pager: _____ /1439

Resident name printed: _____ Dictated by: _____ Intern Pager: _____ /1872

Attending signature: _____ Date: _____

Attending: Ansari Atkisson Bowers Bruch Call Chang Cochrane Curran Ferraro Fuller Gilroy Hayes Kelly Knight Latham
McCraw McFarland Meyer North-Coombes Schrank Sinopoli Smith Surka Von Hofe Wagstaff Watson Weber Weems White