Patient Label (Name and Medical Record Number)	(Barcode) **ALBERT EINSTEIN MEDICAL CENTER** **Admission History and Physical Examination**
Date:	
Time:	
Chief Complaint _____ _____ _____	**PCP Name and Contact Number:** **Patient Contact Information:** **Code Status:** ❒ **Full code** ❒ **DNR/DNI**

History of Present Illness

Review of Systems

Constitutional	❒ Normal	❒ Abnormal	_____
Eyes	❒ Normal	❒ Abnormal	_____
Ear, Nose, Mouth, Throat	❒ Normal	❒ Abnormal	_____
Cardiovascular	❒ Normal	❒ Abnormal	_____
Respiratory	❒ Normal	❒ Abnormal	_____
Gastrointestinal	❒ Normal	❒ Abnormal	_____
Genitourinary	❒ Normal	❒ Abnormal	_____
Musculoskeletal	❒ Normal	❒ Abnormal	_____
Skin/Breasts	❒ Normal	❒ Abnormal	_____
Neurological	❒ Normal	❒ Abnormal	_____
Psychiatric	❒ Normal	❒ Abnormal	_____
Endocrine	❒ Normal	❒ Abnormal	_____
Hematologic/Lymphatic	❒ Normal	❒ Abnormal	_____
Immunologic	❒ Normal	❒ Abnormal	_____

Patient Label
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(Barcode)

ALBERT EINSTEIN MEDICAL CENTER
Admission History and Physical Examination

Past Medical History

_____

_____

_____

_____

_____

Surgical History

_____

_____

_____

Psychosocial/Sexual History

_____

_____

Family History

❒ CAD _____

❒ Diabetes Mellitus _____

❒ Hypertension _____

❒ Cancer _____

❒ Other _____

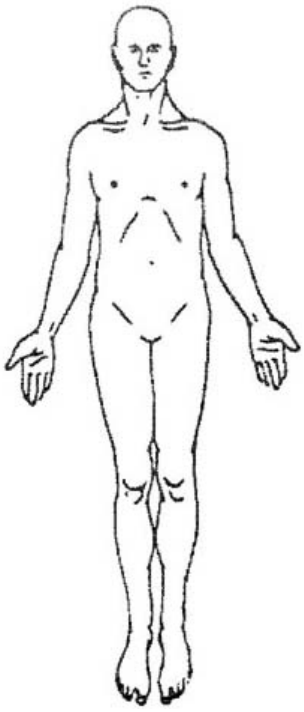
Social History

Tobacco ❒Yes ❒ No Pack Yrs___ Last Use ❒ >1yr ❒ <1yr
❒ Cigarettes ❒ Cigars ❒ Chewing tobacco
Alcohol ❒Yes ❒ No Amount _____
Drugs ❒Yes ❒ No Type _____
Occupation _____
Living Arrangements_____
Others _____

Immunizations

Pneumococcal vaccination
❒ Yes ❒ No Date last given _____
Influenza vaccination
❒ Yes ❒ No Date last given _____
Others: _____
_____

Allergies ❒ No known drug allergy	**Type of Reaction/Side Effects**

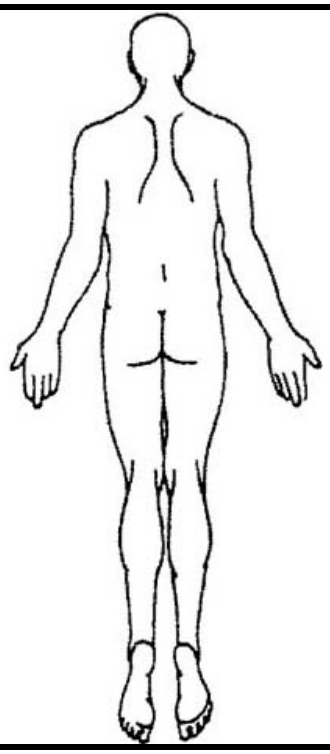


Circle Areas of Pressure Ulceration or Wounds and describe Size and Depth below

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Check below and indicate Site on Diagram

- ❑ Chronic Foley Catheter
- ❑ Chronic IV access Site
  - o Infected
  - o Clean
- ❑ Feeding Tube
- ❑ Tracheostomy Tube



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Physical Examination

Vital Signs:	BP	HR	RR	Temp	Pulse Ox	Weight

Pain: _____ (0-10) 0 – no pain 5 – distressing 10 – unbearable N/O – not obtainable

General Appearance:

Eyes: ❒ Normal

ENT: ❒ Normal

Neck: ❒ Normal

Respiratory: ❒ Normal

Cardiovascular: ❒ Normal

Gastrointestinal: ❒ Normal Rectal Exam:

Genitourinary: ❒ Normal

Lymphatic: ❒ Normal

Musculoskeletal: ❒ Normal

Extremities: ❒ Normal

Neurologic: ❒ Normal

Psychiatric: ❒ Normal

Skin: ❒ Normal

Others:

Labs

EKG/Imaging/Studies

_____

_____

_____

_____

_____

_____

Patient Label
(Name and Medical Record Number)

(Barcode)

ALBERT EINSTEIN MEDICAL CENTER
Admission History and Physical Examination

Cardiovascular

- ❑ **Hypertension** — ❑ Accelerated ❑ Chronic controlled
- ❑ **Hypotension or Shock** — ❑ Cardiogenic ❑ Hypovolemic ❑ Septic
- ❑ **CHF** — ❑ Acute Systolic / Diastolic ❑ Acute on Chronic Systolic / Diastolic ❑ Chronic Systolic / Diastolic
- ❑ **Chest Pain** — ❑ Suspect ACS ❑ Non-cardiac
- ❑ **Syncope** — ❑ Arrythmia/VT ❑ Neucardiogenic ❑ Structural/Valvular

Pulmonary

- ❑ **COPD Exacerbation**
- ❑ **Asthma Exacerbation**
- ❑ **Respiratory Failure** — ❑ Acute ❑ Acute on Chronic

Gastrointestinal

- ❑ **Diverticular Disease** — ❑ With abscess
- ❑ **GI Hemorrhage** — ❑ Esophageal ❑ Gastroduodenal ❑ Lower

Neurological

- ❑ **Cerebrovascular Accident** — ❑ Acute ischemic ❑ Acute hemorrhagic ❑ Chronic
- ❑ **Encephalopathy** — ❑ Metabolic ❑ Dementia

Hematologic

- ❑ **Anemia** — ❑ Acute blood loss ❑ Chronic

Nephrology

- ❑ **Renal Failure** — ❑ Acute ❑ Chronic (Stage 4 or 5)

Metabolic

- ❑ **Diabetes Mellitus** — ❑ With DKA ❑ With Hyper-osmolarity ❑ With retinopathy ❑ With Neuropathy
- ❑ **Malnutrition** — ❑ With Decubitus Ulcers
- ❑ **Abnormal Electrolytes** — ❑ Hyper / Hypo Na^{+} ❑ Hyper / Hypo K^{+} ❑ Hyper / Hypo Ca^{++}
- ❑ **Dehydration** — ❑ With Lethargy

Infectious Diseases

- ❑ **Pneumonia** — ❑ Community aquired ❑ Healthcare associated
- ❑ **Urinary Tract infection** — ❑ Complicated by sepsis ❑ Pyelonephritis

Assessment and Plan

Attending Notes and Comments

Attending Signature_____ Pager No. _____

Date/Time_____

I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note.

Resident Name (Please Print)	PGY	Signature	Pager Number	Date/Time