

DATE: _____ TIME SEEN: _____ on arrival RM: _____ EMS Arrival
 HISTORIAN: patient spouse paramedics _____
 ___HX / ___EXAM LIMITED BY: _____
 unable to obtain

HPI

chief complaint: exposed to: _____
 blood / sputum / saliva / semen / urine _____
 penetrating / topical / mucosal _____

onset / duration: just prior to arrival today yesterday _____ _____ min / hrs / days ago	where: home school neighbor's park work street
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context / mechanism: needle stick *hollow / solid* bite
 cough exposure health care activity spitting IV drug use

location of pain / injuries: head face eye R/L mouth neck chest abdomen back upper mid- lower	<i>-right-</i>	<i>-left-</i>
	shldr hip arm thigh elbow knee f-arm leg wrist ankle hand foot	shldr hip arm thigh elbow knee f-arm leg wrist ankle hand foot

associated symptoms:
 bleeding _____ pain _____
 laceration _____ numbness _____

ROS

NEURO - numbness / weakness _____	RESP - hurts to breathe _____
EYE - problems with vision _____	CVS - chest pain _____
ENT - problems with hearing _____	LYMPH - ankle swelling (R/L) _____
MS - neck pain _____	SKIN - laceration _____
GI - nausea / vomiting _____	CONST - recent fever / illness _____
GU - problems urinating _____	PSYCH - anxiety / depression _____
LNMP _____ preg post-menop _____	

except as marked positive, all systems above reviewed and found negative

PAST HX OF PATIENT ___no chronic disease
 hepatitis A / B / C / non A non B HIV cancer _____

Immunizations: hepatitis A / B / pneumovax UTD / given in ED
 Meds- ___none / see nurses note
 Allergies- ___NKDA / see nurses note

PAST HX OF BODY FLUID SOURCE

unknown
 hepatitis A / B / C / non A non B HIV cancer _____
 recent bacterial illness STD syphilis / GC / Chlamydia _____

SOCIAL HX smoker ___ppd / never / past / quit: _____ ago
 tobacco: use / dependence _____ nicotine: use / dependence _____
 drugs _____ alcohol (recent / heavy / occasional) screening _____

FAMILY HX ___negative

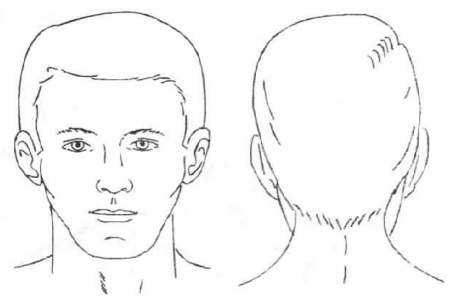
Nursing Assessment Reviewed Vitals Reviewed
 V/S BP _____ HR _____ RR _____ Temp _____

PHYSICAL EXAM

General Appearance
 ___no acute distress ___mild / moderate / severe distress
 ___alert ___anxious / lethargic

HEAD
 ___no evidence of ___see diagram
 trauma ___raccoon eyes / Battle's sign (R/L)

NECK
 ___non-tender ___see diagram
 ___painless ROM ___muscle spasm / decreased ROM
 ___trachea midline ___pain on movement of neck



(see next page for legend)

EYES
 ___PERRL ___unequal pupils R- ___mm L- ___mm
 ___EOMI ___EOM entrapment / palsy (R/L)
 ___subconjunctival hemorrhage
 ___pale conjunctivae

ENT
 ___nml external ___hemotympanum / TM obscured by wax (R/L)
 inspection ___clotted nasal blood (R/L)
 ___no dental injury ___dental injury / malocclusion

RESP / CVS

Circle (positives), backslash negatives, check V normals

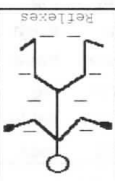
EXTREMITIES
 atraumatic
 nml ROM
 pelvic stable
 no pedal edema
 hips non-tender

BACK
 no CVA
 tenderness
 no vertebral
 tenderness

see diagram
 CVA tenderness (R/L)
 vertebral point-tenderness
 muscle spasm / limited ROM
 see diagram
 bony point-tenderness (R/L)
 painful / unable to bear weight (R/L)
 pulse deficit (R/L)
 limited ROM / ligaments laxity (R/L)
 joint effusion (R/L)

SKIN
 intact
 warm, dry

Glasgow Coma Score
 SCORE = _____
 Eyes - spontaneous (4) to voice (3) to pain (2) none (1)
 Speech - nml (5) disoriented (4) inapprop. (3) incoherent (2) none (1)
 Motor - nml (6) localizes (5) withdraws (4) flexor (3) exten (2) none (1)



oriented to:
 CN'S nml (2-12)
 no sensory deficit
 no motor deficit
 mood & affect nml
 sensory / motor deficit
 depressed mood / affect

NEURO / PSYCH

GENITAL / RECTAL

nml genital exam
 nml vaginal exam
 blood at urethral meatus
 catheter present
 decreased rectal tone
 heme neg, stool
 heme positive stool trace

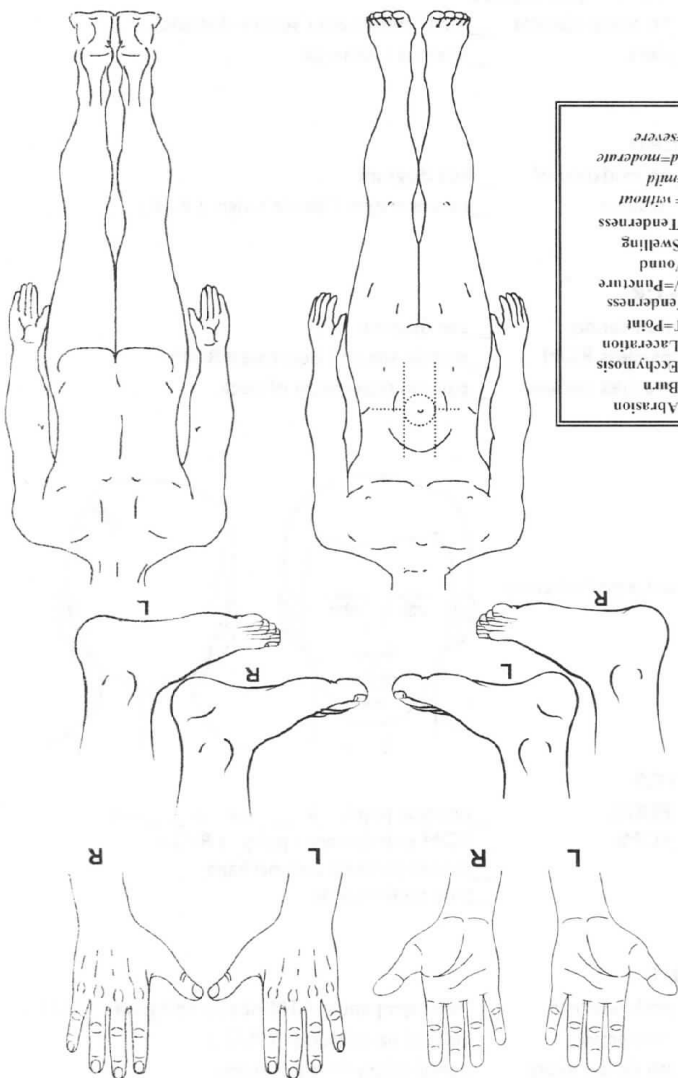
ABDOMEN

chest non-tender
 breath sounds nml
 heart sounds nml
 decreased breath sounds (R/L)
 wheezes / rales / rhonchi (R/L)
 splinting / paradoxical movements
 tachycardia / bradycardia
 rebound / tenderness / guarding :
 generalized RUQ LUQ RLQ LLQ
 no organomegaly
 non-tender
 no organomegaly
 mass / organomegaly

PROGRESS

Time _____
 unchanged
 improved
 re-examined

A=Abrasion
 B=Burn
 E=Echymosis
 L=Laceration
 PT=Point
 Tenderness
 PW=Puncture
 Wound
 Swelling
 T=Tenderness
 =without
 m=mild
 mod=moderate
 sv=severe



Template Complete See Addendum (Dictated / Template #) MD/DO

Wound Description / Repair: _____
 length _____ cm location _____
 linear stellate irregular flap intro: subcut / muscle
 clean contaminated moderately / heavily
 distal NVT: neuro / vasc intact galea intact
 anesthesia: local topical lidocaine / bupivacaine epi / bicarb
 prep: Betadine / other
 irrigated with saline
 wound explored
 to base / in bloodless field
 foreign body identified:
 wood glass metal other
 foreign material removed
 repair: superficial deep complicated
 Wound closed with: adhesive / Dermabond / steri-strips
 no closure required
 SKIN- # _____
 nylon / prolene / staples /
 silk / ethilon / dexon
 SUBCUT- # _____
 vicryl / chromic

PROCEDURES

Xrays done: skull facial spine: C T L S _____
 Interpretation: By me Viewed by me Discsd w/ radiologist

 nml / NAD _____
 abnml: STS DJD FB fracture (see below)

CT done: head spine: C T L S chest abdomen _____
 Interpretation: By me Viewed by me Discsd w/ radiologist

 nml / NAD _____
 abnml:

Fracture:
 Skull: frontal parietal temporal occipital basilar: ant mid post
 R/L linear comminuted depressed
 Facial: nasal orbit malar maxilla zygoma LeFort: I II III
 R/L mandible: ramus angle body condyle subcondyle symphysis

C1 fx: arch: ant post burst (Jefferson fx) lateral mass
 : stable unstable nondisplaced displaced

C2 fx: dens: type I II III extension teardrop
 traumatic spondylo (hangman fx): type I II III
 : stable unstable nondisplaced displaced

C T L S: wedge teardrop burst spinous process
 # _____ : stable unstable nondisplaced displaced

C T L S: wedge teardrop burst spinous process
 # _____ : stable unstable nondisplaced displaced

XRAYS / CT - Continued

PROGRESS - Continued

Time _____ improved unchanged re-examined