

**Patient Chart**

Date: \_\_\_\_\_



**Patient Information**

Patient Name: <i>Jacqueline Henry-Lopez</i>	Patient ID#: <i>35896</i>	Date of Birth: <i>1/28/1980</i>	Age:	Gender: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
Reason for patient's visit? <i>Jacqueline was eating dinner with friends when she felt a tightness in her chest. About 10 minutes later her throat began to itch and she noticed small red bumps around her neck. She has taken Tylenol to help with minor pain but she is still very uncomfortable.</i>				Height: <i>5'7" ft</i> Weight: <i>142 lbs</i>

**Patient Vitals**

	Temperature	Heart Rate/ Pulse	Respiratory Rate	Breathing Sounds	Blood Pressure	SpO2
Standard	98.6°F (37°C)	60-100 bpm	12-20 bpm	clear	90-120/60-80 mmHg	97-99%
<b>Present</b>	<b>98.6°F</b>	<b>125 bpm</b>	<b>33 bpm</b>	<b>wheezing</b>	<b>95/61 mm/Hg</b>	<b>78%</b>

**Review of Patient Symptoms:** Check all that apply

Symptom	Yes	No	Comments	Symptom	Yes	No	Comments
Fever or chills?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Fever	Chest pain or pressure?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Both
Headaches or Migraines?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Headache	Cough or sore throat?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Vision changes?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Shortness of breath?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Dizziness or falling?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Dizziness	Itchy eyes or runny nose?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Nausea or vomiting?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Nausea	Skin rash or sores?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Rash
Diarrhea or constipation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Swelling?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

**Patient Social History**

Occupation/Employer:	<i>Physical Therapist/ Red Stone Hospital</i>			
Marital Status:	<input checked="" type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Do you smoke?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	About _____ per day	
Do you drink alcohol?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	About <u>1</u> per week	
Do you drink caffeinated beverages?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	About _____ per day	

**Patient Previous Medical History:** Check all that apply

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Migraines
Medications:	<i>Acetaminophen (Tylenol)</i>	Drug Allergies:	<i>None</i>

**Family Medical History**

Mother: _____	Sister(s): _____
Father: _____	Children: _____
Brother(s): _____	Grandparents: _____

Completed by: *Mary Jackson, R.N.*

**DELAYED**  
Serious, Non Life Threatening



