



Patient Chart

Date: _____

Patient Information

Patient Name: <i>Michelle Lee</i>	Patient ID#: <i>24683</i>	Date of Birth: <i>12/15/2009</i>	Age:	Gender: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
Reason for patient's visit? <i>Michelle complains of increased nausea, runny nose and mild chest congestion. She vomited directly after lunch and her parents had to pick her up from school. She shared that she had a cough last week but started feeling much better until today.</i>				Height: <i>4'3" ft</i> Weight: <i>71 lbs</i>

Patient Vitals

	Temperature	Heart Rate/ Pulse	Respiratory Rate	Breathing Sounds	Blood Pressure	SpO ₂
Standard	98.6°F/ 37°C	60-100 bpm	12-20 bpm	clear	90-120/60-80 mmHg	97-99%
Present	102 °F	95 bpm	25 bpm	obstructed	102/71 mmHg	94%

Review of Patient Symptoms: Check all that apply

Symptom	Yes	No	Comments	Symptom	Yes	No	Comments
Fever or chills?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Both	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"/>	Sore Throat
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 checked="" type="checkbox"/>	<input type="checkbox"/>	Runny Nose
Nausea or vomiting?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Both	Skin rash or sores?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Diarrhea or constipation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Swelling?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

Patient Social History

Occupation/Employer:	<u>Student</u>			
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 type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	About _____ 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: <u>None</u>		Drug Allergies: <u>None</u>	

Family Medical History

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

Completed by: Mary Jackson, R.N.

MINOR
Walking Wounded



