Name: _____ A/S: _____ DOB: ___/____/____ MRN: _____ Room: _____

CC: _____ All: _____

HPI: _____

PMH/ PSH: _____ Meds:

Soc: _____

[ ] [ ] Lives: _____

[ ] [ ] Tob: _____

[ ] [ ] EtOH: _____

[ ] [ ] FHx: _____

Skin _____ Imaging: _____

HEENT _____

Pum _____

Cardiac _____

Abd _____

Extrem _____

Neuro _____

Problem List/ Plan: _____

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

PCP: _____ Code: _____ Weight: _____

Phone: _____ Diet: _____ PCP Notes [ ]

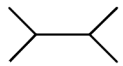
Contact: _____ Access: _____ OSH Notes [ ]

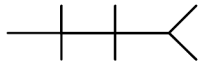
Phone: _____ PPX: _____ Med Rec? [ ]

Pharmacy: _____ D/c: _____ D/c summ? [ ]

Date: ___/___ HD: _____

T: ____ HR: ____ BP: ____/___ RR: ___ O2: ____ I/O: _____





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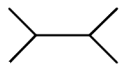
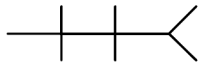
Date: ___/___ HD: _____

T: ____ HR: ____ BP: ____/___ RR: ___ O2: ____ I/O: _____





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Date: ___/___ HD: _____

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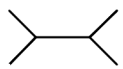

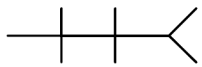

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Date: ___/___ HD: _____

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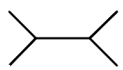

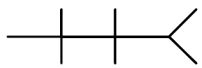

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Date: ___/___ HD: _____

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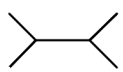

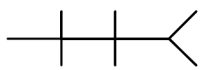

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