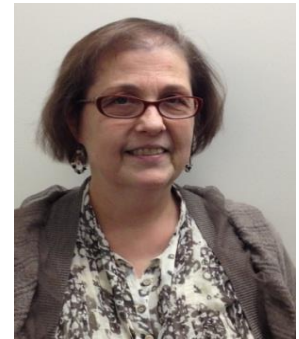


Patient Chart

Date: _____



Patient Information

Patient Name: <i>Janice Little</i>	Patient ID#: <i>73698</i>	Date of Birth: <i>4/6/1966</i>	Age:	Gender: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
Reason for patient's visit? <i>Janice was brought to the ER after surviving a high-speed motor collision. Upon her arrival, she was hysterical and emotional. She complains of sharp pains and tingling from her left leg as well as numbness of toes. She was sent to Room 314 for an X-Ray.</i>				Height: <i>5'1" ft</i> Weight: <i>165 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	98.5°F	112 bpm	30 bpm	clear	60/40 mmHg	89%

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"/>		Chest pain or pressure?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Pain
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"/>	"hysteria"
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 type="checkbox"/>	<input checked="" type="checkbox"/>	
Diarrhea or constipation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Swelling?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Left leg/foot

Patient Social History

Occupation/Employer:	<u>Accountant/ Magnificent Museum Makers, LLC.</u>		
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed
Do you smoke?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	About <u>9 cigarettes</u> per day
Do you drink alcohol?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	About <u>3 glasses</u> per week
Do you drink caffeinated beverages?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	About <u>2 cups</u> 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 checked="" 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): <u>Asthma</u>
Father:	Children:
Brother(s): <u>Prostate Cancer</u>	Grandparents:

Completed by: Mary Jackson, R.N.

IMMEDIATE
Life Threatening Injury

413730

