

Patient Chart

Date: _____



Patient Information

Patient Name: <i>Jerry Pipkins</i>	Patient ID#: <i>67213</i>	Date of Birth: <i>10/17/1943</i>	Age:	Gender: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
Reason for patient's visit? <i>Jerry woke this morning with an intense pain in his chest that has persisted for the past hour. He states the he feels sweaty and is nauseous and lightheaded. His ex-wife states that he has had this pain several times in the past week but she assumed it was just gas.</i>				Height: <i>6'0" ft</i> Weight: <i>213 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	42 bpm	36 bpm	clear	85/45 mmHg	72%

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"/>	Both
Headaches or Migraines?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Cough or sore throat?	<input type="checkbox"/>	<input checked="" 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 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>Retired Police Officer</u>		
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input checked="" type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Do you smoke?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Note: PATIENT QUIT SMOKING TWO YEARS AGO
Do you drink alcohol?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	About _____ per week
Do you drink caffeinated beverages?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	About <u>6 cups</u> per day

Patient Previous Medical History: Check all that apply

<input checked="" 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 checked="" 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>Lisinopril 10mg</u>		Drug Allergies: <u>None</u>	

Family Medical History

Mother:	<u>deceased- complications of diabetes</u>	Sister(s):	<u>1 sister- high blood pressure, diabetes</u>
Father:	<u>deceased- lung cancer</u>	Children:	_____
Brother(s):	_____	Grandparents:	_____

Completed by: Mary Jackson, R.N

IMMEDIATE
Life Threatening Injury

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