

PATIENT EXAM RECORD

Medical Provider Name: _____

PATIENT _____ DOB _____ PT.NO _____

DATE _____ COMPLAINT _____

MALE FEMALE HT. _____ WT. _____ B/P _____ TEMP _____ PULSE _____

Sibilancias *Wheezing* Dolor de cabeza *Headache* Dolor abdominal *Abdominal Pain* Problemas para respirar *Breathing Problems* Tos *Cough*

El lloro *Crying* Fiebre *Fever* Dolor de pecho *Chest Pain* Problemas menstrual *Menstrual Problems* Cargue la perdida *Weight loss*

Fatiga *Fatigue* Diarrea *Diarrhea* Nariz Liquida *Runny Nose* Apoye el dolor *Back Pain* Palidezca/anemia *Pale/Anemia*

Picazón en los ojos *Itchy Eyes* Sudores *Sweats* Calambres *Cramps* Dolor de hueso *Bone Pain* Garganta adolorida *Sore Throat*

PERTINENT MEDICAL HISTORY:

	NO	YES	If yes, explain
Heart Disease	_____	_____	_____
Hypertension	_____	_____	_____
Diabetes	_____	_____	_____
Asthma	_____	_____	_____
Renal	_____	_____	_____
Pregnant	_____	_____	_____
Other	_____	_____	_____
Past History	_____	_____	_____

Allergies _____ Current Medications _____

PHYSICAL EXAM: Normal Abnormal

EENT	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia	_____	_____	_____
Extremities	_____	_____	_____

LAB: HCT. _____ Glucose _____ Malaria _____ Urinalysis _____ Urine pregnancy _____

TREATMENT _____

