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 ____

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Allergies ____________________ Current Medications ______________________________________

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PHYSICAL EXAM:

	Normal	Abnormal	
EENT	____	_____	____
Heart	____	_____	____
Lungs	____	_____	____
Abdomen	____	_____	____
Genitalia	____	_____	____
Extremities	____	_____	____

LAB: HCT._________ Glucose_________ Malaria_______ Urinalysis___________ Urine pregnancy________________________

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DIAGNOSIS____

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MEDICATIONS PRESCRIBED ____

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