Medical Record #:_____
Medical Provider Name:_____

PATIENT EXAM RECORD

PATIENT_____ DOB_____ PT.NO_____

DATE_____ COMPLAINT_____

MALE FEMALE 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_____

Diagnosis/Treatment **LIST ALL MEDICATIONS PRESCRIBED.**

[ ] Anemia - _____
[ ] Asthma - _____
[ ] Diabetes - _____
[ ] GERD - _____
[ ] Health Maintenance - _____
[ ] Hypertension - _____
[ ] Osteoarthritis -_____
[ ] Pregnancy -_____
[ ] Other - _____
_____
_____
_____
_____
_____ Updated 2021