

ADMISSION H&P / SOAP _____		Pt initials / Age / Sex: _____	Room: _____	MRN: _____	Date / Time seen: _____	Service / Preceptor: _____	Code: _____
S — SUBJECTIVE CC: _____ HPI: OLDCARTS — Onset · Location · Duration · Character · Aggravating/Alleviating · Radiation · Timing · Severity. Include pertinent positives AND negatives. 					ED / TRANSFER COURSE Pertinent labs, imaging, meds & interventions given prior to arrival. Note who called you and why. 		
					Source of Hx: ☐ Patient ☐ Family ☐ Chart ☐ EMS Reliability: ☐ Good ☐ Limited		

REVIEW OF SYSTEMS — circle + for positive, slash for negative. "All other systems reviewed and negative."					
CONSTITUTIONAL	PULMONARY	GI	NEURO	ENDO	PSYCH
☐ Fever / chills	☐ Cough	☐ Nausea / vomiting	☐ Dizziness / vertigo	☐ Polyuria / polydipsia	☐ Depression
☐ Night sweats	☐ Sputum (color)	☐ Abdominal pain	☐ Weakness	☐ Heat / cold intolerance	☐ Anxiety
☐ Weight loss / gain	☐ Hemoptysis	☐ Diarrhea	☐ Numbness / tingling	☐ Hair / skin Δ	☐ Agitation
☐ Fatigue	☐ Dyspnea / DOE	☐ Constipation	☐ Seizure	☐ Hypoglycemia	☐ Hallucinations
☐ Appetite Δ	☐ Wheeze	☐ Melena / BRBPR	☐ Confusion		☐ SI / HI
☐ Sleep Δ	☐ Pleuritic pain	☐ Jaundice	☐ Speech Δ	HEME / ID	OTHER / PERTINENT
HEENT	☐ Orthopnea / PND	☐ Last BM: _____	☐ Gait Δ / falls	☐ Easy bruising	_____
☐ Headache	CARDIAC	GU	MSK	☐ Bleeding	_____
☐ Vision Δ	☐ Chest pain	☐ Dysuria	☐ Joint pain	☐ Lymphadenopathy	_____
☐ Hearing Δ / tinnitus	☐ Palpitations	☐ Frequency / urgency	☐ Swelling	☐ Sick contacts	_____
☐ Sore throat	☐ Syncope	☐ Hematuria	☐ Myalgias	☐ Recent travel	_____
☐ Dysphagia	☐ Edema	☐ Flank pain	☐ Back pain	SKIN	_____
	☐ Claudication	☐ Retention / incontinent	☐ Recent trauma	☐ Rash	_____
				☐ Wounds / ulcers	_____
				☐ Pruritus	_____

PMH — controlled? dx date? complications?	HOME MEDS — drug / dose / route / freq / adherence	SURGICAL HX & PRIOR ADMITS

ALLERGIES + reaction	SOCIAL HX			FAMILY HX & ADVANCE CARE
	Lives with / home:	Tobacco (pk-yr):	Occupation:	1° relatives: ☐ CAD ☐ CVA ☐ DM ☐ CA ☐ HTN ☐ Clots
	Functional status / ADLs:	Alcohol / drugs:	Travel / exposures / pets:	Code status / MPOA / goals:

O — VITALS	O — PHYSICAL EXAM — add DDx-specific maneuvers; document what you actually did	NORMAL EXAM TEMPLATE — amend, don't copy																												
T max / current	GEN	GEN: A&O x3, well-appearing, in no acute distress, seen at bedside.																												
BP (range)	HEENT	HEENT: Normocephalic, atraumatic. PERRLA, EOMI, sclerae anicteric. Nares patent, oropharynx clear, mucous membranes moist.																												
MAP	NECK	NECK: Supple, full ROM, no LAD, no thyromegaly, no JVD, trachea midline.																												
HR / rhythm	RESP	RESP: Unlabored on room air. CTAB, no wheezes/rales/rhonchi. No accessory muscle use, symmetric chest rise.																												
RR	CV	CV: RRR, normal S1/S2, no murmurs/rubs/gallops. No pedal edema. Radial & DP pulses 2+ bilaterally, cap refill <2 s.																												
SpO ₂ & O ₂ device / FiO ₂	ABD	ABD: Soft, non-distended, non-tender. Bowel sounds active x4 quadrants. No guarding, rebound, or organomegaly.																												
Pain / accu-check	EXT	EXT: Normal tone and bulk, full ROM, no deformity, no calf tenderness or asymmetric swelling.																												
Weight kg / IBW / BMI	NEURO	NEURO: Alert & oriented x3, CN II-XII grossly intact, 5/5 strength in all extremities, sensation intact to light touch, reflexes 2+ symmetric, no focal deficit, normal gait.																												
I / O & urine output	SKIN / wounds	SKIN: Warm, dry, intact. No rashes, lesions, erythema, or breakdown. No pressure injuries noted.																												
ACCESS / LINES / TUBES (note day #)	PSYCH	PSYCH: Normal mood and affect, linear thought process, appropriate insight and judgment. Denies SI/HI.																												
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VTE ppx:	Diet:	Telemetry / monitoring:	Abx (day # / de-escalate?):	Code status:
GI ppx (indication?):	Bowel regimen / mobility:	IV access / fluids:	Consults:	Dispo / anticipated LOS:

